Federation of American Hospitals

Charlene K. MacDonald
President and CEO

June 8, 2026

Via electronic submission at *http://www.regulations.gov*

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1849–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates; Quality Programs Requirements; and Other Policy Changes (CMS–1849–P)

Dear Dr. Oz:

The Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule, published in the Federal Register on April 14, 2026 (91 Fed. Reg. 19311). The comments contained in this letter address the IPPS and LTCH PPS provisions of the Proposed Rule. FAH's comments on the proposed Comprehensive Care for Joint Replacement Expanded (CJR-X) Model are being submitted separately under separate cover.

FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens', and cancer services.

FAH appreciates the Administration's continued focus on improving the efficiency, transparency, and accountability of the Medicare program while supporting high-quality patient care. FAH and its member hospitals share the goal of advancing policies that strengthen patient outcomes, modernize program operations, and promote sustainable access to care for Medicare beneficiaries.

At the same time, hospitals continue to face significant financial, operational, and workforce pressures, alongside rapid changes in payment policy, quality measurement, technology, and coverage challenges across both Medicare Advantage and traditional Medicare. In this environment, it is critical that CMS advance policy changes in a manner that is transparent, operationally feasible, and supported by sufficient testing and stakeholder engagement.

While the Proposed Rule includes several constructive policies, FAH remains concerned that a number of the proposed payment and quality program changes are being advanced on compressed timelines, without adequate methodological transparency, and in ways that could create instability in hospital reimbursement and quality performance measurement. Our comments focus on ensuring that CMS policies are implementable, data-driven, and aligned with the shared objective of preserving access to high-quality care for patients and communities.

EXECUTIVE SUMMARY

FAH appreciates the opportunity to comment on the FY 2027 IPPS and LTCH PPS proposed rule and urges CMS to adopt the following recommendations.

The FY 2027 market basket update is inadequate and should be recalibrated using the most recent data, with a forecast error correction policy to address persistent underestimation. The proposed 3.2 percent market basket update, reduced by 0.8 percentage points for productivity, again understates the inflationary pressures hospitals continue to face. Since FY 2021, the cumulative IPPS update has fallen 4.2 percentage points behind cumulative inflation, and recent BLS data show consumer prices rising 3.8 percent over the 12 months ending April 2026. The result is a payment update that does not keep up with the real cost of caring for Medicare beneficiaries — a gap that compounds year over year and erodes the resources hospitals have available to maintain access and quality. CMS should use the most recent available data when finalizing the FY 2027 update and should adopt a forecast error correction policy to address future underestimation.

Medicare Disproportionate Hospital (DSH) uncompensated care payments for FY 2027 do not reflect hospital operational realities of caring for more uninsured patients. CMS should broaden the data sources behind the Factor 2 calculation to capture the rising uninsured rate. A series of regulatory and legislative changes adopted since CMS finalized its actuarial projections including the March 2025 Marketplace Integrity rule, the May 2026 Notice of Benefit and Payment Parameters, and the health care provisions of the Pub. Law 119-21 (known as Working Familes Tax Cut Legislation) are projected to increase the uninsured population materially in FY 2027. The Factor 2 calculation in the Proposed Rule does not account for these developments. Even a modest 0.5 percentage point upward adjustment to the projected uninsured rate would increase the uncompensated care pool by approximately $410 million, helping ensure that hospitals serving the uninsured and underinsured are not left further behind.

CMS should remove negative payment adjustments associated with the Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome Performance Measure (THA/TKA PRO-PM) in the Hospital Inpatient Quality Reporting (IQR) Program, revise the measure, and exclude it from use in the TEAM model, as well as from consideration for the proposed mandatory CJR-X model or any other CMS program until a comprehensive redesign is developed and validated. The measure, in its current form, imposes substantial and unfeasible data-collection burdens on hospitals and patients, and its design flaws disproportionately affect rural, safety-net, and low-volume facilities, undermining quality goals. A redesigned THA/TKA PRO-PM must incorporate a defensible case minimum, feasible data-collection and evidence-based response-rate standards suitable for low-volume settings, explicit exclusion criteria for patients who decline, and clinically realistic data-collection timelines that align with everyday workflows.

CMS should not finalize the quality measure changes proposed for Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) Program, and the Hospital IQR Program. Integration of Medicare Advantage (MA) data, the shift to a two-year performance period, and the move to ICD-10 risk adjustment together represent a sweeping redesign of foundational quality programs without adequate transparency, testing, or hospital readiness. Each of the three changes raises serious concerns on its own; combined, they will create volatile and unreliable performance scores that drive penalty exposure without improving the quality of care delivered to patients. CMS should delay these proposals by at least one year, release the underlying model specifications now so hospitals can assess potential impact, and complete additional reliability and social risk factor testing before any of these measures are used in payment determinations.

All CMMI models, including TEAM, should be voluntary. Innovation Center models are most successful when providers have the opportunity to opt in, demonstrate results, and compete on performance rather than operate under a federal mandate. The FAH continues to strongly oppose mandatory provider participation in CMMI models. CMMI's authority is limited to testing voluntary alternative payment models, and Congress reserved for itself the authority to make permanent or mandatory changes to the Medicare program.

FAH objects in the strongest terms to both a voluntary participation option for physician-owned hospitals and to the waiver of the statutory limitations on physician-owned hospitals. CMS requests information on a potential voluntary participation option only for hospitals with physician ownership, including potentially those that do not comply with section 1877(d)(1) and (i) of the Social Security Act. FAH does not oppose physician ownership itself. Rather, FAH has long opposed arrangements that permit physicians to refer patients to facilities in which they have a financial interest. Physician-owned hospitals are not required to maintain a nurse on staff 24/7. They do not always have a physician on call. They do not need to operate an emergency department or be equipped to handle all levels of medical

emergencies, creating an unlevel playing field with community hospitals. Voluntary opt-in would skew the TEAM model test by mixing mandatory and voluntary participation, a concern CMS itself has acknowledged. If finalized, this policy would effectively create a CJR-X opt-out available only to physician-owned hospitals, compromising the integrity of both models. Moreover, an opt-in for non-compliant physician-owned hospitals would inappropriately waive section 1877(d) and (i) of the Social Security Act and would exceed CMS's testing and waiver authority under section 1115A(b) and (d)(1). The resulting limited-service hospitals would also resurrect the very problems that Congress sought to directly address when enacting the express limitations on new and expanded physician-owned hospitals in section 1877 of the Act.

Finalize the Proposed Freeze of the LTCH High-Cost Outlier (HCO) Fixed-Loss Threshold and Pursue Broader LTCH Reform including Outlier Policy Reforms. FAH supports CMS's proposal to maintain the LTCH HCO fixed-loss threshold at $78,936 for FY 2027 rather than allow it to increase further under the current methodology. However, the threshold remains substantially higher than historical levels, limiting support for the most clinically complex and costly LTCH patients. Accordingly, FAH urges CMS to restore the pre-FY 2022 methodology for calculating the HCO threshold, account for reconciliation recoupments in future threshold-setting, and rescind Change Requests 13566 and 14233, which significantly expanded outlier reconciliation and increased provider burden and payment uncertainty.
The FAH appreciates the opportunity to offer comments on the FY 2027 IPPS and LTCH PPS Proposed Rule. Our detailed comments are included in the following pages in Appendix A of our letter. If you have any questions or would like to discuss further, please do not hesitate to contact Alyssa Keefe, SVP Head of Policy at akeefe@fah.org or (202) 624-1500.

CONCLUSION

FAH appreciates the opportunity to comment on the FY 2027 Hospital IPPS and LTCH PPS proposed rule. We look forward to continuing to work with CMS to advance policies that support patient access, promote high-quality care, and ensure the long-term stability of the nation's hospitals. Should you have any questions regarding our comments or require additional information, please contact Alyssa Keefe, SVP Head of Policy at akeefe@fah.org or 202-624-1500.

Sincerely,

/s/
Charlene MacDonald
President and CEO

APPENDIX A:
FAH Detailed Comments on FY 2027 IPPS and LTCH PPS Proposed Rule (CMS-1849-P)

I. Inpatient Hospital and LTCH Updates for FY 2027 (Parts V.B and VIII.C; Addendum Parts II and V)

CMS proposes a market basket update of 3.2 percent for FY 2027. This market basket update is a product of CMS' reliance on historical data to forecast FY 2027 hospital operating costs using a hospital market basket that reflects a 2023 base year. In addition, CMS has proposed reducing the proposed market basket update of 3.2 percent by 0.8 percentage points for productivity. This productivity adjustment contemplates improbable and overstated gains in productivity for the hospital sector as noted by the CMS Office of the Actuary (OACT) itself and detailed below.

Background

Under section 1886(b)(3)(B)(iii) of the Act, CMS is required to update hospital rates based on:

> the percentage, estimated by the Secretary before the beginning of the…fiscal year, by which the cost [of] … inpatient hospital services…will exceed the cost…for the preceding 12-month cost reporting period or fiscal year.

The update is subject to the productivity adjustment and further adjustments for hospitals that fail to submit quality information and/or are not meaningful EHR users.[1]

CMS is proposing to use a hospital market basket of 3.2 percent to update both IPPS and LTCH PPS rates for FY 2027. This market basket is based on the forecast of CMS' contractor, IHS Global Insight, Inc. (IGI). IGI's fourth quarter 2025 forecast (with historical data through the third quarter of 2025) for the hospital market basket is 3.2 percent. IGI's fourth quarter 2025 forecast of productivity is 0.8 percent.

The proposed rule indicates that CMS' forecast of the FY 2027 IPPS and LTCH PPS market baskets and the offsets for productivity will be updated if more recent data become available before the final rule. If CMS follows past practice, this will mean that the FY 2027 final rule update will be based on IGI's second quarter 2026 forecasts of the FY 2027 inpatient hospital and LTCH markets basket with historical data through the first quarter of 2026.

FAH strongly urges CMS to use the later data on the market basket increase for FY 2026 as it has in past years.

Upward pressure on hospital costs occurring throughout the pandemic and other global economic developments has not been fully reflected in the updates that hospitals have received dating back to FY 2021. From 2021 to 2024, the combined IPPS update has been 4.2 percentage points below the cumulative market basket change and the LTCH PPS update has been 4.3 percentage points below the cumulative market basket change.[2] This was largely driven by an unprecedented and extraordinary understatement of the market baskets for FY 2022 and FY 2023—actual inflation in those years warranted an additional 3.4 percentage point increase in IPPS rates and an additional 3.5 percentage point increase in LTCH PPS rates. While there has been more stability in the projection of inflation and its later measurement based on more recent information for FY 2025 and FY 2026, FAH notes that the United States appears again to be in a period of high inflation and unstable economic conditions due to world events.

The inadequacy of the proposed 2.4 percent updates is underscored by current inflation data. According to the Bureau of Labor Statistics, the all-items Consumer Price Index rose 3.8 percent over the 12 months ending April 2026, leaving the proposed update 1.4 percentage points below overall inflation (prior to subtracting 0.8 percentage points for total factor productivity). Even though the CPI measures a different set of goods and services than the IPPS and LTCH PPS market baskets, it is suggestive that later economic information on which the inflation updates are based shows prices growing more rapidly than reflected in the data used to forecast the FY 2027 IPPS updates. These events are bringing renewed concern about instability in the estimate of inflation and the potential for the IPPS and LTCH PPS updates to significantly understate inflation that hospitals are experiencing.

FAH recommends that CMS consider adopting a forecast error correction policy for the IPPS and LTCH PPS if FY 2027 inflation based on later information is higher than a threshold amount beginning with FY 2027 in the event CMS again underestimates hospital inflation in a period of economic uncertainty and instability.[3]

Productivity

Pursuant to section 1886(b)(3)(B)(xi)(II) of the Act, the Secretary adjusts the IPPS market basket increase by the "10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as produced by the Secretary for the 10-year period ending with the applicable fiscal year)." This adjustment is also applied to the LTCH PPS market basket pursuant to section 1886(m)(3)(A)(i). The theory behind the offset for economy wide total productivity is that the hospital sector should be able to realize the same productivity gains as the general economy.

However, CMS actuaries also take issue with the assumption that hospitals can recognize the same kinds of productivity gains as the general economy. In a memorandum dated June 2, 2022, OACT stated: "over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent." The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.[4]

FAH shares OACT's skepticism regarding the offset to the hospital market basket for the 10-year average in economy-wide nonfarm productivity. One reason that hospitals may not be able to realize the same growth in general economy wide productivity is that hospital services are highly labor intensive. As labor represents nearly 70 percent of the index, hospitals have little opportunity to obtain productivity gains from non-labor inputs as may be occurring in other industries that are less labor intensive.

FAH understands that CMS is required by law to adjust the IPPS and LTCH PPS market basket updates for productivity. However, FAH asks CMS to consider that the adjustment for productivity reduces the update below what even OACT says is reasonable for hospitals to achieve when deciding on our request to make an adjustment for forecast error if CMS again underestimates FY 2027 inflation.

There are two other issues of concern to FAH with the productivity offset. First, CMS has applied the productivity adjustment exclusively to restrict the increase in Medicare payments. In the one year (FY 2021) where productivity in the non-farm business section did not improve and measured TFP declined, CMS set the productivity adjustment to 0.0 rather than increasing payments. The cumulative effect of these reductions year over year, and the asymmetric treatment of declines in economy-wide productivity, lead to an increasing gap between payments and the cost of providing services, leaving hospitals increasingly underfunded, which ultimately restricts the amount of care they can provide.

CMS addressed this issue in a final rule in FY 2021 without an opportunity for public comment. In the FY 2021 IPPS/LTCH final rule, CMS indicated that IGI's June 2020 estimate of 10-year productivity would be -0.1 percent. CMS indicated:

> …under section 1886(b)(3)(B)(xi)(I) of the Act, the Secretary is required to reduce (not increase) the hospital market basket percentage increase by changes in economy-wide productivity. Accordingly, we are applying a 0.0 MFP adjustment to the FY 2021 market basket percentage increase.[5]

While section 1886(b)(3)(B)(xi)(I) of the Act states that "such percentage increase shall be reduced by the productivity adjustment" it does not follow that the statute necessarily requires that the productivity adjustment be a subtraction from the otherwise applicable update. Reducing the otherwise applicable update by a negative number would be an addition to the update. **FAH believes that CMS should make this issue subject to public notice and comment rulemaking before having adopted it as a final policy.**

In other statutory contexts, Congress has specified if the addition or subtraction of a variable may be overridden. For instance, under section 1833(i)(2)(C)(ii) of the Act, Congress specified "the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points." Under section 1886(h)(2)(D)(iv)(II) of the Act, Congress specified application of an update to some per resident amounts shall be equal to the consumer price index "reduced (but not below zero) by 2 percentage points. If Congress meant that the productivity adjustment is zero if it's not positive, Congress could have specified that in subclause (II) but did not. **Therefore, it is FAH's contention that CMS should have increased the IPPS and LTCH PPS updates in FY 2021 for productivity rather than applying no adjustment.**

The Proposed Rule Would Unlawfully Continue to Apply Adjustments Under TMA § 7(b)(1)(B) to the IPPS Standardized Amount in FY 2027

The Proposed Rule, like the IPPS/LTCH Final Rules for FYs 2024, 2025 and 2026, would continue a series of adjustments under section 7(b)(1)(B) of the TMA, Abstinence Education, and QI Program Extension Act of 2007, Pub. L. No. 110-90 as amended ("TMA"), totaling negative 0.9412 percent. These section 7(b)(1)(B) adjustments, however, are expired by the plain text of the statute, making their proposed continuation in FFY 2024 and subsequent years unlawful. The Proposed Rule, however, does not mention section 7(b) of the TMA and fails to provide any rationale or legal basis for effectively making the net adjustments under section 7(b)(1)(B) permanent. **FAH strongly urges CMS to eliminate this error for FY 2027 with a positive 0.9412% adjustment to the standardized amount, which would eliminate the remaining adjustment under section 7(b)(1)(B) of the TMA and effectuate their statutory expiration.**

Beginning with FY 2014,[6] CMS has made the following adjustments under section 7(b)(1)(B)(ii) and (iii) of the TMA:

FY	Adjustment	Cumulative Adjustment
2014	–0.8%	–0.8%
2015	–0.8%	–1.6%
2016	–0.8%	–2.4%
2017	–1.5%	–3.9%
2018	+0.4588%	–3.4412%
2019	+0.5%	–2.9412%
2020	+0.5%	–2.4412%
2021	+0.5%	–1.9412%
2022	+0.5%	–1.4412%
2023	+0.5%	–0.9412%

The FY 2014 through FY 2017 adjustments were made under section 7(b)(1)(B)(ii) of the amended TMA, followed by the adjustments for 2018 through 2023, which were made under amended section 7(b)(1)(B)(iii) of the TMA.[7] All of these adjustments, both positive and negative, are adjustments under section 7(b)(1)(B) of the TMA, and thus are all subject to section 7(b)(4), which prohibits continuing any section 7(b)(1)(B) adjustments into years beyond FY 2023.

TMA § 7(b)(4) provides that "[n]othing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2016, and 2017 and each succeeding fiscal year through fiscal year 2023." This language makes clear that CMS must fully eliminate the payment adjustment under section 7(b)(1)(B) for any year not listed in section 7(b)(4). And, in fact, that is precisely what CMS did in the FY 2013 Final Rule by fully eliminating the section 7(b)(1)(B) adjustment at that time with a one-time positive 2.9% adjustment.[8]

As illustrated in the above table, the series of negative and positive adjustments made under TMA section 7(b)(1)(B) between FYs 2014 and 2023 have produced a cumulative, net adjustment of negative 0.9412%. As such, in order to comply with Congress' mandate that the adjustment under section 7(b)(1)(B) not apply to any year after FY 2023, CMS was required to fully eliminate this remaining section 7(b)(1)(B) adjustment with a one-time, offsetting positive adjustment of 0.9412% for FY 2024. CMS, however, failed to do so in FY 2024, and the standardized amount for FY 2024 remains impermissibly reduced by the section 7(b)(1)(B) adjustments. In response to comments on this issue, in the FY 2024 IPPS/LTCH Final Rule, CMS focused on its authority to adopt and apply the adjustments under section 7(b)(1)(B)(ii) and (iii) of the TMA in past fiscal years.[9] But, the FY 2024 IPPS/LTCH Final Rule failed to discuss or give any meaning to Congress's clear and unequivocal prohibition under section 7(b)(4) on applying any of these section 7(b)(1)(B) adjustments to discharges after FY 2023 and Congress's prohibition in section 7(b)(2) on the inclusion of an adjustment under section 7(b)(1)(B) "in the determination of the standardized amounts for discharges occurring in a subsequent year." Put simply, Congress' instruction to adopt and apply the adjustments under section 7(b)(1)(B)(ii) and (iii) in FY 2014 through 2023 does not authorize the continuation of these adjustments in FY 2024 and subsequent years, and such a continuation is expressly prohibited under section 7(b)(2) and (4) of the TMA. And the Proposed Rule, if finalized, would continue this error in FY 2027 by again continuing the adjustments adopted under section 7(b)(1)(B) as permanent reductions to the standardized amount.

In the FY 2026 IPPS/LTCH Final Rule, CMS asserted that the continuation of the recoupment adjustments after FY 2023 did not violate TMA section 7(b)(2) because it "complies with [the] instruction" to "'ignore recoupment adjustments' when 'calculat[ing] and apply[ing] the annual "percentage increase"'" to base rates."[10] A review of the IPPS/LTCH Final Rules for FY 2024 through the present, however, confirms that CMS did not exclude any TMA section 7(b)(1)(B)

adjustments when calculating and applying the annual percentage increase. For example, in the FY 2024 IPPS/LTCH Final Rule, CMS removed five adjustments from the base rate before applying the FY 2024 update factor and FY 2024 adjustments, but did not follow this practice with respect to the TMA section 7(b)(1)(B) adjustments. Instead, CMS retained the cumulative section 7(b)(1)(B) adjustments in the FY 2023 rate when calculating and applying the annual percentage increase for FY 2024. Having failed to "ignore" the section 7(b)(1)(B) adjustments or otherwise address the requirements of section 7(b)(2) or 7(b)(4) when calculating and applying the annual percentage increase in FY 2024 and later years, CMS should remedy the issue for FY 2027.

The FY 2024, FY 2025 and FY 2026 IPPS/LTCH Final Rules and the FY 2027 Proposed Rule provide no rationale for diverging from CMS' established approach to eliminating section 7(b)(1)(B) adjustments to comply with section 7(b)(4) of the TMA with a one-time offsetting restoration to the standardized amount. Nor do the rulemakings cite to any authority for making the section 7(b)(1)(B) adjustments permanent. In light of the foregoing concerns and express limitations on CMS' authority, **FAH urges CMS to end the erroneous continuation of the statutorily expired section 7(b)(1)(B) adjustments in FY 2027 with a one-time, offsetting positive adjustment of 0.9412%.**

II. Outlier Payments (Addendum Part II.A.4.i)

For FY 2027, CMS has proposed that a case will be eligible for a high-cost outlier payment when the cost of the case exceeds the sum of the prospective payment rate for the MS-DRG plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus the proposed fixed loss threshold of $51,704. This proposed threshold represents an increase of $11,307 to the current fixed loss threshold, a nearly 28 percent proposed jump in one year. Moreover, it would compound significant growth in the fixed-loss threshold in recent years—with the proposed increase, the fixed-loss threshold will have nearly doubled since FY 2020, while the fixed-loss threshold only increased by 15 percent over the prior decade.

Continuation of Methodological Changes Adopted for FY 2020, with Modified Calculation of Estimated Reconciliation of Outlier Payments

CMS proposes to again use the same basic methodology to calculate the fixed loss threshold as it has since FY 2014, applying methodological refinements that were first applied in the FY 2020 IPPS rulemaking.

Projecting Outlier Reconciliation. First, CMS proposes to again account for outlier reconciliation in the FY 2027 outlier threshold calculation. The Federation again commends CMS for proposing to continue addressing the impact of outlier reconciliation in setting the FY 2027 fixed-loss threshold. FAH has repeatedly requested that CMS release information on the outlier reconciliation process and data showing the amounts recovered so that it can evaluate the impact of the reconciliation process on the outlier threshold, and we do so again here. Using the FY 2021 cost report data in the December 2025 HCRIS extract and provider specific file (PSF) values and applying the new outlier reconciliation criteria set forth in CR 13566 produced a percentage of operating outlier reconciliation dollars to total Federal operating payments that would result in no adjustment to the threshold (0.0 percent). Watson Policy Analysis (WPA) matched CMS's calculation of the reconciliation factor. Because this result is inconsistent with the prior historical data and is unlikely to be an accurate predictor of outlier reconciliations for FY 2027, CMS proposes instead to hold the data constant and use the percentage from the FY 2025 IPPS/LTCH PPS Final Rule (–0.4 percent). The Federation supports this proposal to address anomalies in the FY 2021 data, but continues to object to CMS's application of the new reconciliation criteria in CR 13566 without first going through notice and comment rulemaking.

Projecting Charge Inflation. Second, the Proposed Rule charge inflation factor calculation conceptually mirrors the method CMS adopted in the FY 2020 final rule, relying on charge data from the most recent publicly available MedPAR files to compute the one-year charge inflation factor. For the Proposed Rule, CMS used the December 2024 MedPAR file of FY 2024 charge data and the December 2025 MedPAR file of FY 2025 charge data to compute the proposed charge inflation factor; and for the FY 2027 final rule, CMS proposes using the more recent MedPAR files from March 2025 for the FY 2024 time period and March 2026 for the FY 2025 time period. With this data, CMS has computed a proposed one-year charge inflation factor of 7.310 percent and has converted that into a proposed two-year charge-inflation-factor of 15.154 percent.

CMS does not propose to apply any trims to the charge data in the FYs 2024 and 2025 MedPAR data files. In contrast, for the LTCH threshold, CMS appropriately "remove[d] all claims from providers whose growth in average charges was a statistical outlier" to project charge inflation for FY 2026,[11] and is proposing to use the same charge inflation factor for FY 2027. CMS explained, "We remove these statistical outliers prior to calculating the charge inflation factor because we believe they may represent aberrations in the data that would distort the measure of average charge growth." *Id.*

Although the IPPS charge inflation projection methodology necessarily involves data from a larger number of hospitals and claims, statistical outliers still "distort the measure of average charge growth" for IPPS hospitals. We therefore urge CMS to apply trims to the statistical outliers when computing the final charge inflation factor for the IPPS outlier threshold.

In addition, we note that CMS's significantly higher proposed charge inflation factor for FY 2027 suggests that CCRs would decrease more rapidly than CMS's 2.25% projection of the change in CCRs (discussed below), given that CMS is also projecting cost inflation for FY 2027 will remain relatively steady. CMS should consider this discrepancy as well in determining whether the charge inflation factor requires any downward adjustment.

We also continue to believe that CMS should disclose all aspects of its edits to the most current data used for the Proposed Rule and commit to the same process and methods when it recalculates the threshold for purposes of the final rule. Additionally, CMS should commit to make public the data files it uses for the final rule, including all edits and calculations, when it publishes the final rule.

Projecting CCRs. Third, the Proposed Rule applies the same method, first adopted in the FY 2014 IPPS Rule, to project the change in CCRs. For FY 2027, CMS has proposed comparing the CCRs in the December 2023 update of the PSF to the CCRs in the December 2024 update of the PSF and has computed a proposed one-year national operating CCR adjustment factor of 0.977497. The final CCR adjustment factors for FYs 2013 through 2024 have consistently been below 1.0,[12] and the proposed one-year national operating CCR adjustment factor for FY 2027 is consistent with this historic experience.

Extreme Charge Cases Significantly Skew the Fixed Loss Threshold

As we have in past years, the Federation also asks CMS to consider whether it is appropriate to include extreme cases when calculating the fixed-loss threshold. If the fixed-loss threshold is finalized as proposed, it will have doubled between FY 2019 and FY 2027, and much of that increase occurred over just three years, from FY 2022 to FY 2025. WPA conducted various examinations and probing of data to understand the factors that drove these significant increases to the fixed-loss threshold, and observed that the inclusion of extreme cases in the calculation of the threshold, the rate of which are increasing over time, significantly impacts CMS's determination of the fixed-loss threshold.[13]

In the IPPS rate-setting process for the MS-DRG relative weights, statistical outliers (*i.e.*, extreme cases) are generally removed from calculations on the basis that they improperly skew those calculations. In calculating the outlier threshold, however, those statistical outliers are not excluded from the calculation. To observe the impact of these statistical outliers on the calculation of the threshold, WPA calculated how the proposed FY 2027 threshold would differ after the removal of cases that had total charges above particular trim points. The results of WPA's analysis are included in the tables below:[14]

Scenario	Cases remaining	Removed cases	FLT	Percentage of cases removed
Base	6,754,195	0	$51,830	0.00
Trim at: 5,000,000	6,753,862	333	$49,851	0.00
Trim at: 4,750,000	6,753,817	378	$49,701	0.01
Trim at: 4,500,000	6,753,760	435	$49,471	0.01
Trim at: 4,250,000	6,753,663	532	$49,176	0.01
Trim at: 4,000,000	6,753,514	681	$48,768	0.01
Trim at: 3,750,000	6,753,325	870	$48,313	0.01
Trim at: 3,500,000	6,753,106	1,089	$47,826	0.02
Trim at: 3,250,000	6,752,802	1,393	$47,102	0.02
Trim at: 3,000,000	6,752,477	1,718	$46,400	0.03
Trim at: 2,750,000	6,752,036	2,159	$45,680	0.03
Trim at: 2,500,000	6,751,424	2,771	$44,813	0.04

Trim at: 2,250,000	6,750,500	3,695	$43,801	0.05
Trim at: 2,000,000	6,749,335	4,860	$42,755	0.07
Trim at: 1,750,000	6,747,683	6,512	$41,495	0.10
Trim at: 1,500,000	6,745,018	9,177	$39,903	0.14
Trim at: 1,250,000	6,740,130	14,065	$37,804	0.21
Trim at: 1,000,000	6,730,456	23,739	$34,942	0.35
Trim at: 750,000	6,706,647	47,548	$30,810	0.70
Trim at: 500,000	6,635,227	118,968	$24,514	1.76
Trim at: 250,000	6,275,778	478,417	$14,217	7.08

The table above illustrates that the removal of a relatively small number of extremely high cost cases (using total charges as a proxy for cost) from the calculation significantly decreases the threshold. For example, removing all cases with total charges above $2,500,000 (3,695 cases) lowers the threshold over $8,000. Removing all cases at certain other thresholds, lower than $2,500,000, but still high enough to be considered extreme high-cost cases, drives the threshold down even further. For example, removing all cases with total charges above $1,000,000 (23,739 cases) drives the threshold down over $13,000, and removing all cases with charges above $500,000 (118,968 cases) drives the threshold down over $27,316.

Furthermore, these high charge cases are increasing quickly over time, but still represent a very small percentage of total cases. To demonstrate this trend of an increase in extremely high charge cases, WPA created the following table illustrating the number of cases with covered charges above $1.5 million for each of the past several years:[15]

Year	Number of cases over $1.5 million	Percentage of total cases	Number of unique providers
2011	926	0.0088%	272
2012	994	0.0098%	272
2013	1,092	0.0111%	283
2014	1,329	0.0141%	306
2015	1,539	0.0161%	320
2016	1,733	0.0185%	334
2017	2,291	0.0250%	403
2018	2,650	0.0286%	398
2019	3,128	0.0348%	441
2020	3,666	0.0474%	474
2021	4,719	0.0650%	530
2022	5,482	0.0803%	594
2023	6,620	0.0980%	607
2024	7,460	0.1108%	614
2025	9,306	0.1375%	660

If this trend continues (that is, if the number (and proportion) of extreme cases continues to increase each year), the impact of this population of cases on the threshold will likewise increase. Thus, it is imperative that CMS carefully consider what is causing this trend, whether the inclusion of these cases in the calculation of the threshold is appropriate, or whether a separate outlier mechanism should apply to these cases that more closely hews outlier payments to marginal costs.

FAH urges CMS to carefully study this problem as it pertains to outlier payment policy. Not only is this consistent with the calculation process used for IPPS rate setting generally, but it will also produce a threshold that more accurately reflects the universe of cases.

Using the Most Recent Data to Calculate the Threshold

We also note that with each IPPS rulemaking for more than a decade (with the exception of FYs 2022 and 2024), the final fixed-loss threshold established by CMS has consistently been lower than the threshold set forth in the proposed

rule, and the variance between the proposed and final thresholds has generally exceeded 4 percent. The table below derived from WPA Report at p.6 shows this trend of regular, significant variances between proposed and final fixed-loss thresholds:

FY	Final	Proposed	Variance	% of Variance
2009	$ 20,045	$ 21,025	$ (980)	-4.66%
2010	$ 23,140	$ 24,240	$ (1,100)	-4.54%
2011	$ 23,075	$ 24,165	$ (1,090)	-4.51%
2012	$ 22,385	$ 23,375	$ (990)	-4.24%
2013	$ 21,821	$ 23,630	$ (1,809)	-7.66%
2014	$ 21,748	$ 24,140	$ (2,392)	-9.90%
2015	$ 24,626	$ 25,799	$ (1,173)	-4.55%
2016	$ 22,544	$ 24,485	$ (1,941)	-7.93%
2017	$ 23,573	$ 23,681	$ (108)	-0.46%
2018	$ 26,537	$ 26,713	$ (176)	-0.66%
2019	$ 25,769	$ 27,545	$ (1,776)	-6.45%
2020	$ 26,552	$ 26,994	$ (521)	-1.93%
2021	$ 29,064	$ 30,006	$ (942)	-3.31%
2022	$ 30,988	$ 30,967	$ 21	0.07%
2023	$ 38,859	$ 43,214	$ (4,355)	-11.21%
2024	$ 42,750	$ 40,732	$ 2,018	4.95%
2025	$ 46,217	$ 49,237	$ (3,020)	-6.13%
2026	$ 40,397	$ 44,305	$ (3,908)	-8.82%
2027		$ 51,704		

Although FAH can only speculate as to why this drop in the threshold occurs, we believe the decline is most likely due to the use of updated CCRs and/or additional/other data in calculating the final threshold. This again emphasizes that CMS must ordinarily use the most recent data to appropriately calculate the outlier threshold.

With regard to the current rulemaking, WPA was able to replicate the threshold within 0.5%. Thus, we have high confidence that WPA understands CMS's methodology and has accurately modeled that methodology.

FY 2027 Outlier: Conclusion

The Federation is not proposing a threshold for FY 2027. While we have confidence in the work of WPA, its work is dependent on a large number of variables in the outlier calculation. We also note that the impact of the inclusion of extreme cases in the calculation of the fixed loss threshold is significant and we urge CMS to carefully study this trend and whether outlier payment policy should be adjusted so that it is fair to all hospitals that fund outlier payments. Finally, we recognize that with the release of the MedPAR final data with additional claims, which will lead to new weights being calculated, and with updated cost to charge ratios, it is appropriate to recalculate the fixed loss threshold from the data that will be released with the final rule.

III. MS-DRG Classifications and Relative Weights (Part II.C)

The Federation generally supports the proposed changes recommended for MS-DRG and/or ICD-10 code classification changes for FY 2027 except for the sections discussed below.

Basis for Proposed FY2027 MS-DRG Updates (Part II.C.1.b)

For FY 2027, CMS provided a test version of ICD-10 MS-DRG GROUPER Software, Version 44 along with conversion files to assist with analysis. FAH appreciates the public availability of the V44 draft GROUPER. However, consistent with prior year comments, we continue to experience challenges modeling the proposed changes without a batch GROUPER.

Although the GROUPER provided supports manual case-by-case analysis and limited batch analysis, it does not provide users with the capability to conduct meaningful large-scale analysis in a timely manner. The analysis is limited by complex GROUPER logic revisions that eliminate cluster logic or use new procedure codes that are not part of CMS'

AOR/BOR report. The lack of transparency with MS-DRG shifts outlined in the Proposed Rule combined with CMS data variances in AOR/BOR report precludes the replication of data for reliable analysis. **FAH therefore requests that CMS make public a Batch z/OS version of the test GROUPER for all future rulemaking.**

MDC 05 (Disease and Disorders of the Circulatory System): WiSE® CRT System (Part II.C.3)

CMS provided table 6P.2a for ICD-10-PCS procedure codes that would be assigned to MS-DRGs 210/211. FAH reviewed the codes and identified cases in the V44 grouper that did not assign MS-DRGs 210/211 for the revision/replacement of the pacemaker, instead grouping to MS-DRGs 242-244 for the insertion of the pacemaker. These cases involved broken leads with procedures in which the broken lead and the battery were replaced (since it was close to end of life of battery). This appears to be inconsistent with the MS-DRG noted within the listed table and the actual narrative of the MS-DRGs (i.e., replacement vs insertion).

In evaluating the ICD-10-PCS codes listed in Table 6P.2a, FAH identified six codes that should map to new MS-DRGs 210 or 211 based on their inclusion in Table 6P.2a, but when tested with the V44 draft GROUPER, instead mapped to MS-DRGs 242-244 for the insertion of a pacemaker. These assignment errors occurred with the two operating room procedures identified by ICD-10-PCS procedure codes 02PA3MZ (Removal of cardiac lead from heart, percutaneous approach) and 0JPT0PZ (Removal of cardiac rhythm related device from trunk subcutaneous tissue and fascia, open approach), and with the four non-operating room procedures identified by ICD-10-PCS procedure codes 02H63JZ (Insertion of pacemaker lead into right atrium, percutaneous approach), 02HK32Z (Insertion of monitoring device into right ventricle, percutaneous approach), 02HK3MZ (Insertion of cardiac lead into right ventricle, percutaneous approach) and 0JH605Z (Insertion of pacemaker, single chamber rate responsive into chest subcutaneous tissue and fascia, open approach).

An additional screenshot below displays a specific scenario where these procedures group to MS-DRG 244 (Permanent Cardiac Pacemaker Implant without CC/MCC) instead of the anticipated MS-DRG 211. If surgical hierarchy is being applied, this should not be considered in this scenario as it requires more than one code to replace the pacemaker (i.e., both the insertion and removal codes for the lead and device).

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MS-DRG Assignment with Medicare Code Editor V44.0 NPRM


Patient Name: test1             Medical Record Number: 1

Admit Date: 10/01/2026  Discharge Date: 10/05/2026      Birth Date: 03/19/1958
Optional Information:

Patient Account Number: 1
Age in Years: 68                Sex: Female
Discharge Status: 01  Home or self-care

MDC: 05 DISEASES AND DISORDERS OF THE CIRCULATORY SYSTEM
Final
DRG: 244 Permanent Cardiac Pacemaker Implant without CC/MCC
Cost Weight: 01.7799
MS-DRG Grouper version 44.0 NPRM (October 1, 2026) used.
HAC Status: Not Applicable.

Admitting Diagnosis:
T82110A Breakdown (mechanical) of cardiac electrode, init encntr


Principal Diagnosis:
T82110A Breakdown (mechanical) of cardiac electrode, init encntr (DRG)
        POA: Yes, present at the time of inpatient admission

Secondary Diagnoses:
No secondary diagnoses.


Principal Procedure:
02PA3MZ Removal of Cardiac Lead from Heart, Percutaneous Approach (OR)

Secondary Procedures:
02H63JZ Insertion of Pacemaker Lead into Right Atrium, Perc Approach (DRG)
0JH606Z Insert Pace. Dual Cham in Chest Subcu/Fascia, Open (DRG)
0JPT0PZ Remove Card Rhythm Dev from Trunk Subcu/Fascia, Open (OR)
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Additionally, CMS indicated within their analysis of the WiSE® CRT system procedure that a stakeholder requested to reassign the procedure codes that describe the insertion of the WiSE® CRT System from MS-DRGs 243 and 244 to MS-DRGs 228 and 229. However, there were no cases as the procedure code was not effective until October 1, 2024. **FAH requests transparency with the details of the MS-DRG shifts from CMS. After reviewing the analysis provided by CMS, FAH referenced the AOR/BOR report provided with CMS data and it is unclear why over 40 MS-DRGs within MDC 05 demonstrate variances in volume between V43 and V44 Groupers. Example of a few unclear shifts as the data in the AOR/BOR report does not reflect the information in the rule for declines include MS-DRG 228, 229, 270, 271, 272, 309 or increases with MS-DRGs 242, 243, 266, 278, 279.**

MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)
Spinal Fusion and Pelvic Fixation Procedures (Part II.C.4.a)

CMS proposes further refinement of the MS-DRG logic with spinal fusions with a focus on extensive spinal fusions. For FY 2027, CMS proposes the addition of three new spinal fusion MS-DRGs—523, 524 and 525 (Extensive or Complex Spinal Fusion Procedures Except Cervical with MCC, with CC and without CC/MCC)—that will shift from existing MS-DRGs 402, 426, 427, 447, 448, 450, 451, 456, 457 and 458. The procedure codes for the new MS-DRGs are reflected within CMS table 6p.3a and involve various clusters of codes.

Although FAH supports the proposed FY 2027 revision for spinal fusion, FAH would like to note a concern with transparency for data modeling. These MS-DRGs have experienced revisions for the last three fiscal years, resulting in unique differences in spinal fusions that are contingent upon the respective fiscal year. For example, cases that group into MS-DRG 426 would be unique in FY 2025, FY 2026, and the proposed FY 2027. This requires recalibration to compare the MS-DRG with a batch GROUPER for an accurate comparison. Additionally, MS-DRG 426 has a substantial

proposed weight difference for FY 2027, with the relative weight proposed to decrease from 11.0212 to 9.2898. It is not possible to simply compare current spinal MS-DRGs calculated with the V43 GROUPER, as cases will shift out of MS-DRG 426 because of the changes made over the last three years.

Hip or Knee Procedures with Periprosthetic Joint Infection (Part II.C.4.b)

FAH is concerned that the seven changes outlined in the proposed rule for hip/knee MS-DRGs have a broad redistribution of cases across multiple MS-DRGs beyond just the new and deleted MS-DRGs impacting existing MS-DRGs. The following comments request consideration of new MS-DRGs rather than reassignment to debridement MS-DRGs 463, 464, and 465, as well as greater clarity regarding the proposed MS-DRG reassignments and case shifts between MS-DRGs.

FAH believes that these significant changes result in lack of transparency with the identification of MS-DRG shifts. There is a significant disparity in the AOR/BOR report for deleted and new MS-DRGs. With the current GROUPER (V43) there are 42,703 cases within the six deleted MS-DRGs of 466, 467, 468, 485, 486 and 487. There are only 16,374 cases that will shift into the four new MS-DRGs of 400, 403, 404 and 449 with the proposed GROUPER (V44). This leaves a net difference of over 26,329 cases that are shifting from the deleted MS-DRGs into existing MS-DRGs.

FAH reviewed the AOR/BOR report within MDC 08 for any MS-DRGs that were not the new or deleted MS-DRGs for shifting MS-DRGs. It demonstrates that there is a variance of over 26,916 cases across MS-DRG shifts in 25 unique MS-DRGs. This variance within individual MS-DRGs is rarely just a few cases but more significant with increases as high as 13,769 cases (MS-DRG 464) and decreases as low as -1,652 cases (MS-DRG 489).

There are significant volume increases with shifts into MS-DRGs 463, 464, 465 (Debridement MS-DRGs) that total a net increase of 29,560 cases. There are MS-DRGs that have increases and decreases that are not even mentioned in the rule to have potential MS-DRG shifts (***e.g.***, MS-DRGs 469, 470, 475, 478, 479, 480, 481, 482, 483, 488, 489, 493, 494, 498, 499, 500, 501 and 502). It is clear there will be a shift with the MS-DRGs but it is unclear where the MS-DRGs are shifting to or from. There are significant volume decreases in MS-DRGs 488 and 489 (Knee Procedures without PDX of Infection with and without CC/MCC). However, there was no mention in the proposed rule of changes to knee procedures without the diagnosis of an infection.

FAH is concerned with the shift that resulted in the volume increase of over 29,560 cases into MS-DRGs 463, 464 and 465. This would result in a negative impact on data comparisons over time. The distribution of cases prior to the FY 2027 proposed rule, within MS-DRGs 463, 464 and 465, would no longer be comparable with the distribution going forward. FAH requests greater transparency regarding MS-DRG shifts so that the volume changes reflected within the AOR/BOR reports are fully explained in the IPPS proposed rule. **FAH also strongly recommends the creation of new MS-DRGs rather than shifting a substantial volume of hip and knee procedures into existing debridement MS-DRGs.**

Lastly, CMS acknowledged there is a new ICD-10-PCS code (XW0V0BC) that may be implemented on October 1, 2026 for CERAMENT® V. This is described as antibiotic-eluting of Vancomycin whereas CERAMENT® G is antibiotic-eluting of Gentamicin. FAH requests that CMS designate this new code as a non-operating room procedure so that it groups to the new MS-DRGs that recognize the antibiotic-eluting bone void filler (e.g.463, 474, 477, 480, 492, 616 and 628).

Proposed Changes to the MS-DRG Diagnosis Codes for FY 2027 SDOH – Homelessness, Inadequate Housing, and Housing Instability (Part II.C.12.c.1)

CMS noted they finalized the changes to severity levels in FY 2024 for Z59.00, Z59.01 and Z59.02 from Non-CC to CC. In FY 2025, CMS expanded this to seven codes describing inadequate housing and housing instability from Non-CC to CC. CMS has re-evaluated these ten codes and now proposes to change all severity level designations from CC to non-CC:

- Z59.00 – Z59.02 (Homelessness)
- Z59.10-Z59.12, Z59.19 (Inadequate housing)
- Z59.811-Z59.812, Z51.819 (Housing Instability)

FAH strongly believes that the homelessness and housing status codes should not change in severity from CC to Non-CC based on data demonstrating that these conditions are expected to significantly increase hospital resource use. Beginning in FY 2021, CMS began utilizing both a mathematical formula (*i.e.*, volume and severity impact), and the application of nine guiding principles to propose MCC/CC status changes as part of annual

rulemaking. These conditions satisfy the data-driven component of the analysis with robust evidence of higher resource utilization. In addition, they implicate a number of the guiding principles indicating expected resource use by a secondary guidance, including: (1) post-operative condition/complication impacting recovery; (2) typically requires higher level of care (that is, intensive monitoring, greater number of caregivers, additional testing, intensive care unit care, extended length of stay) and (3) impedes patient cooperation and/or management of care. For example, for a patient with acute exacerbation of chronic heart failure, homelessness is highly correlated with reduced adherence to the care plan outside the hospital, delays in seeking care (resulting in greater severity at hospital presentment), and longer lengths of stay.

Retaining the current CC designation for these diagnosis codes would also be consistent with CMS's treatment of chronic disease codes in the FY 2008 IPPS/LTCH PPS Final Rule. In that rulemaking, CMS "applied the criterion that chronic diagnoses having a broad range of manifestations are not assigned to the CC list a*s long as there are codes available that allow the acute manifestations of the disease to be coded separately*." 72 Fed. Reg. 47,154 (emphasis added). The Proposed Rule, however, does not identify any other codes that would be appropriate to capture the impact of homelessness on resource utilization. These conditions are more akin to "advanced chronic diseases [that], even in the absence of a separately coded acute manifestation, significantly adds to the treatment complexity of the patient." 72 Fed. Reg. 47,154. Therefore, under CMS's existing standards, the ten codes at issue should retain their CC designation.

IV. Add-On Payments for New Services and Technologies for FY 2027 (Part II.E)

Alternative Pathway for Breakthrough Devices – Ceribell Delirium Monitor System (Part II.E.6.a.5)

CMS notes that new technology add-on payments for the Ceribell Delirium Monitor System is being sought for FY 2027. It is important to note that the new technology add-on payment is ending for FY 2027 for Ceribell Status Epilepticus Monitor. As a result, CMS is proposing to exclude cases that report ICD-10-CM diagnosis codes that CMS believes would identify patients with status epilepticus in combination with the procedure code (See table 10.2).

FAH is supportive of the new technology add-on payments but doesn't believe the presence or absence of diagnosis codes identifying patients with status epilepticus is the most effective manner to make that determination as to if the monitor system is for Status Epilepticus or Delirium. It is possible that the monitor may be utilized and no diagnosis could be present and only a symptom would be reported. It is also possible for a patient to have both conditions and use the Ceribell Delirium Monitor System, and it would be inappropriate to exclude delirium cases from new technology add-on payments for the system based on co-existing conditions. Accordingly, FAH recommends that CMS create a distinct ICD-10-PCS code for the Ceribell Delirium System, rather than continuing to use the same procedure code used for the Ceribell Status Epilepticus Monitor. Alternatively, CMS could use ICD-10-CM signs and symptoms codes (e.g., altered mental status, confusion) that may be clinically representative of delirium, that may or may not be present after monitoring, but support use of the technology for this purpose.

Proposed Alternative Pathway repeal for New Technology Add On Payment and Outpatient Prospective Payment System (OPPS) Device Pass-through (Part II.E.7)

CMS's proposed repeal of the alternative pathway for new technology add-on payment (NTAP) devices would weaken the Medicare pathway that is specifically designed to bridge the gap between innovation and standard inpatient payment rates. While FAH acknowledges that the traditional pathway would remain, repeal of the alternative pathway has the risk of discouraging device innovation by reducing the likelihood that manufacturers can secure early Medicare adoption.

Many technologies enter the market with strong safety and efficacy data but without long-term outcomes or large comparative studies. Requiring proof of substantial clinical improvement disadvantages breakthrough technologies that are clinically promising but still accumulating real-world evidence. If hospitals cannot recover a portion of the incremental cost during the adoption period, access may be limited, which is inconsistent with the intent for broad beneficiary access.

The majority of NTAP devices are also approved under the alternative vs. traditional pathway. While CMS, in collaboration with the FDA, has announced plans to implement the proposed RAPID Coverage Pathway, the underlying regulation remains pending at this time. As a result, it is difficult to fully evaluate how the RAPID pathway would compare to or replace the existing NTAP alternative pathway, including whether it would provide comparable access, predictability, and support cost for emerging technologies.

NTAP helps CMS maintain a balanced payment system: it preserves budget predictability in the base DRG structure while still allowing temporary, targeted support for breakthrough technologies. Repeal of the alternative pathway would send the wrong signal at a time when CMS should be encouraging adoption of high-value technologies, not creating barriers.

V. Hospital Wage Index for Acute Care Hospitals (Part III; Addendum Part II.A.4.g)

Continued Transition for the Discontinuation of the Low Wage Index Hospital Policy (Part III.F.6. and Addendum Part II.A.4.g)

The Federation supports CMS' proposal to adopt a narrow transitional exception to the calculation of FY 2027 IPPS payments for low wage index hospitals significantly impacted by the discontinuation of the low wage index hospital policy, but strongly urges CMS to forego the proposed, unlawful budget neutrality adjustment and to instead continue implementing the transition in a non-budget neutral manner. As CMS notes, temporary transition policies ensure that the effects of payment policy changes (here, the elimination of the low wage index hospital policy) are phased in, thus mitigating short-term instability and payment fluctuations that negatively impact hospitals and promoting the principles of certainty and predictability under prospective payment systems.

For FY 2020, CMS adopted a low-wage index policy where it increased wage index values below the 25th percentile by one-half the difference between the hospital's otherwise applicable wage index and the 25th percentile wage index value. CMS applied a budget neutrality adjustment for the low wage index policy such that increasing the wage index for the affected hospitals did not increase Medicare spending.[16] This low wage index hospital policy and associated budget neutrality adjustment remained in place through FY 2024 and was the subject of litigation, including in *Bridgeport Hospital v. Becerra*. On July 23, 2024, the Court of Appeals for the D.C. Circuit Court held that the Secretary lacked authority under section 1886(d)(3)(E) of the Act or under the adjustments language of section 1886(d)(5)(I)(i) of the Act to adopt the low wage index hospital and that the policy and related budget neutrality adjustment must be vacated.[17] Then, on December 11, 2024, the Court of Appeals for the Ninth Circuit similarly held CMS lacked statutory authority to implement the policy and that vacatur should be awarded.[18]

On October 3, 2024, CMS published an interim final rule with comment (IFC) in the Federal Register revising its previously announced FY 2025 IPPS policies and rates. In the IFC, CMS recalculated the IPPS hospital wage index to remove the low wage index hospital policy for FY 2025 and remove the low wage index budget neutrality factor from the FY 2025 standardized amounts.[19]

For FY 2027, CMS proposes to continue a transition policy first implemented in the IFC for FY 2025. In the FY 2023 IPPS rule, CMS adopted a 5-percent cap on year-to-year decreases in each hospital's wage index value regardless of the circumstances causing the decline. For FY 2025, CMS limited the decrease in the wage index value for hospitals that no longer benefit from the low wage index hospital policy to 5 percent, consistent with past practice to address significant changes to payment policies and the wage index cap policy at 42 C.F.R. § 412.64(h)(7). The transitional policy for FY 2026 limited wage index reductions between FY 2024 and FY 2026 to 9.75 percent for hospitals significantly impacted by the discontinuation of the low wage index hospital policy. Likewise, the transition policy proposed for FY 2027 would limit wage index reductions for impacted hospitals between FY 2024 and FY 2027 to 14.2625 percent (5 percent per year). **FAH supports this continued transitional policy and appreciates CMS' attention to the difficulties faced by hospitals that are significantly impacted by discontinuation of the low wage index hospital policy.**

FAH, however, urges CMS to apply this transitional exception without any budget neutrality adjustment, consistent with its practice in FY 2025. As CMS has acknowledged, section 1886(d)(5)(I)(i) of the Act does not require budget neutrality for these "adjustments."[20] In fact, as FAH has emphasized in past comments, CMS does not have authority under subsection (d)(5)(I)(i) or otherwise to reduce IPPS payments for purposes of budget neutrality. Subsection (d)(5)(I) restricts the Secretary's authority to adopt budget neutrality adjustments to only adjustments for transfer cases, and budget neutrality is neither required nor authorized in other circumstances. Clause (i) of § 1395ww(d)(5)(I) authorizes the Secretary to "provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." No budget neutrality authority is included under this clause. Rather, Congress adopted clause (ii) at CMS' express request in order to provide limited authority for a budget neutrality adjustment only when CMS makes an adjustment under clause (i) for transfer cases. This clause states:

> In making adjustments under clause (i) for transfer cases . . . the Secretary may make adjustments...to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

Because the statute explicitly restricts the Secretary's authority to adopt budget neutrality adjustments in connection with adjustments for transfer cases, budget neutrality is neither required nor authorized in other circumstances. For this reason, CMS' transitional policy may properly be adopted as an adjustment under 42 U.S.C. § 1395ww(d)(5)(I)(i) but may not be implemented in a budget neutral manner. Accordingly, FAH urges CMS to remove the Proposed Rule's budget neutrality adjustment to the IPPS standardized amounts for the transitional policy.

VI. Payment Adjustment for Medicare DSH and Uncompensated Care Payments (Part IV.E)

The Federation is concerned that the uncompensated care payments proposed for FY 2027 fail to adequately address the significant and growing uncompensated care costs borne by DSH-eligible hospitals and fail to adequately project both the DSH payments that would be made in the absence of section 1886(r) of the Social Security Act and, more significantly, the uninsured rate anticipated for FY 2027. In light of the volatility introduced by various legislative and regulatory policies, the Federation strongly urges CMS to carefully review its projections for FY 2027 based on updated data and a wider range of sources in order to avoid understated uncompensated care payments that fail to meet congressional objectives behind section 1886(r) of the Social Security Act.

Calculation of Proposed Factor 2 for FY 2027 (Part IV.E.2)

Factor 2 of the uncompensated care payment calculation adjusts Factor 1 for the change in the number of uninsured individuals in the United States since 2013, the last year before the disproportionate share hospital payments were reduced and uncompensated care payments began. The higher the uninsured rate, the larger the aggregate dollar amount of uncompensated care payments that are distributed to IPPS hospitals under Factor 3. Because Factor 2 turns exclusively on the uninsured rate, it is critical that CMS' estimate accurately accounts for significant factors that are expected to fuel the uninsured rate. For FY 2027, the Federation is concerned that legal changes over the past year will reduce coverage in ways that are not addressed by the proposed estimates and that must ultimately be captured in the final Factor 2 estimates.

Recent regulatory and legislative proposals are expected to increase the uninsured rate and the associated Factor 2 calculation for FY 2027. For example, CMS estimated that the March 19, 2025 Marketplace Integrity and Affordability proposed rule would reduce enrollment during calendar year 2026 by between 750,000 to 2 million.[21] Likewise, in the May 20, 2026 Notice of Benefit and Payment Parameters, CMS estimated an enrollment decline of between 1.2 and 2 million, which would fuel a corresponding increase in the uninsured rate.[22] In addition, Public Law (Pub. L.) 119-21, which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation, includes a number of health care provisions that impact the financing of Medicaid programs and limit eligibility for Medicaid and Marketplace coverage. These provisions are anticipated to further fuel growth in the uninsured rate in FY 2027. **These regulatory and legislative changes post-date the NHEA projections that were certified by OACT for this proposed rule, and FAH strongly urges CMS and the OACT to broaden their data sources to more fully reflect current estimates of the uninsured rate in FY 2027 in light of proposed legal changes.** CMS and the OACT should likewise expand the prospective analysis as shifting market conditions, including growing inflation, are likewise expected to increase the burden of uninsured and underinsured patients.

We note that the Factor 2 estimates have significant impacts on the UC-DSH funding available to support critical hospital services to the uninsured and underinsured. For example, even acknowledging an additional 0.5 percentage point of growth in the uninsured rate in FY 2027 (9.16 percent uninsured), would increase the proposed uncompensated care pool by approximately $410 million above CMS' proposal.

VII. Payment for Indirect and Direct Graduate Medical Education (Part V.F) — New Medical Residency Training Programs

Background:

When the Balanced Budget Act (BBA) of 1997 capped the number of residents a hospital may count for direct graduate medical education (DGME) and indirect medical education (IME), it also provided authority for CMS to establish rules that allowed the caps to be adjusted for "medical residency training programs established on or after January 1, 1995."

CMS defines a "new medical residency training program" in 42 C.F.R. § 413.79(l) as "a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995."[23] In 2009, CMS identified "supporting factors to be considered in determining whether a program is new,"[24] but made no amendments to 42 C.F.R. § 413.79(l).

Rulemaking Issues:

In the FY 2025 IPPS rule, CMS undertook to "establish in rulemaking additional criteria for determining program newness," including by proposing that "at least 90 percent of the individual resident trainees (not FTEs) in the program as a whole must not have had previous training in the same specialty as the new program." 89 Fed. Reg. 35,934,36,222–23 (May 2, 2024). Under that proposal, if more than 10 percent of the trainees (not FTEs) transferred from another program at a different hospital/sponsor in the same specialty, even during their first year of training, CMS proposed that this would render the program (but not the entire hospital or its other new programs, if applicable) ineligible for new cap slots. In addition, CMS requested information regarding newness thresholds and criteria for the teaching staff and program director.

CMS did not finalize any new policies regarding the definition of a new medical residency training program in the FY 2025 IPPS rule. Rather, with respect to the appropriate criterion regarding newness of residents, CMS summarized comments received and initiated another request for information (RFI) on the issue. CMS further indicated it would carefully consider comments received regarding the newness of the program director and faculty in future rulemaking. Based on public comments in response to this RFI, CMS believes that it should not restrict the ability of new residency programs to hire experienced faculty and program directors. CMS believes that considering the previous training experience of residents should provide a sufficient guardrail to ensure that existing programs are not being transferred between hospitals and treated as "new" for purposes of the caps.

In addition to the program receiving initial accreditation from the appropriate accrediting body on or after January 1, 1995, CMS proposes that, for programs started on or after October 1, 2026, the program will only be considered new if at least 90 percent of the individual resident trainees (not FTEs) did not have previous training in the same specialty as the new program. Under this proposal, CMS would evaluate whether the 90 percent threshold is met during the entire 5-year cap building period.

The proposed rule distinguishes between a resident that was accepted, enrolled and participated in an internal medicine residency program from a resident who was not enrolled in an internal medicine program but who may have done a rotation in internal medicine as part of the requirements for a different specialty. Also, an individual who enters a subspecialty training program after having previously completed an initial board residency would be counted as a new resident.

CMS proposes to create a limited exception to the counting rules for certain residents admitted via the National Resident Matching Program (the Match) or other third-party resident matching programs whose results are binding on hospitals. The proposal would exclude from the count of trainees—both numerator and denominator of the 90 percent calculation—any individuals with previous experience training in another program in the same specialty who enter the new program as first-year residents through the Match or another binding third-party resident matching program or are displaced from a closed program. However, such residents could continue to be counted as new residents for determining DGME and IME payment and establishing the cap at the end of the 5-year cap building window.

Residents displaced from a closed program would also be excepted from the 90 percent determination of whether a residency program is new or not. These residents may continue to be counted as residents above the cap but not on the cost report lines for new residents and instead on the lines for displaced residents. Displaced residents would not be counted for determining a hospital's cap at the end of the cap building period.

CMS is also proposing an exception to the 90 percent requirement for small residency programs defined as those accredited for 16 or fewer residents. For these programs, CMS is not proposing an alternative threshold to 90 percent but only that these programs must have an initial accreditation after January 1, 1995.

There would be no restrictions on commingling of residents under these new proposed rules as CMS had previously considered in the FY 2025 IPPS rule. The 90 percent threshold would only be determined based on new residents in the new medical residency program. In addition, CMS would allow a hospital to have two or more residency programs in the same specialty if the second or subsequent program has separately received initial accreditation and at least 90

percent of the individual trainees (not FTEs) entering the program during the five-year cap building period are new. The programs would not be required to have separate program directors and staff.

CMS' proposals are largely consistent with public comments FAH made to CMS on the FY 2025 IPPS proposed rule. FAH thanks CMS for considering our comments and clarifying that residents in subspecialty training would continue to be considered new for purposes of subspecialty training. Further, FAH is pleased to see that CMS will not adopt any restrictions on prior faculty or program director experience for a medical residency training program to be considered new. **FAH, however, requests that CMS consider reducing the threshold for residents that do not have prior training in the program's specialty or subspecialty from 90 percent to 80 percent.** FAH believes that there will be at least some instances where new residency programs will need to accommodate residents with prior training coming from other programs, and it would be impractical to limit a new residency program's ability to do so over the 5-year cap building period. An 80 percent threshold will provide more flexibility to a hospital to accommodate residents with prior training while still retaining the newness of the program. Moreover, a threshold of 80 percent better aligns with CMS's policy objective of distinguishing newly established programs from transferred programs. Alternatively, CMS could refine the proposal to temporally weight the calculation of residents that do not have prior training in the specialty or subspecialty (*i.e.*, counting resident years rather than residents) so that new programs are not unduly constrained when replacing residents that do not complete the program.

In addition, FAH has concerns about CMS's treatment of hospitals that started new programs prior to October 1, 2026, including those that are in the cap-building phase after the effective date of the final rule on this subject. Briefly, although 42 C.F.R. § 413.79(l) only looks at the date of "initial accreditation" or the date the program "begins training residents" to assess newness, the preamble discussion in the Proposed Rule indicates that CMS considers its existing policy to require that the "overwhelming majority" of residents and staff not come from previously existing programs in the same specialty and that the program director be new. FAH disagrees with this characterization of CMS' policy that was never adopted in regulation.

In any case, in light of CMS's well-reasoned and appropriate conclusion that it is inappropriate to assess the newness of a medical residency training program based on the programs use of a program director and staff with prior experience, CMS should expressly repudiate its prior assertions regarding newness criteria. In no circumstances should CMS and its contractors apply the properly abandoned program director and staff newness criteria to the evaluation of residency programs' newness. Likewise, with respect to any "overwhelming majority" standard, such standard was not adopted in notice-and-comment rulemaking as required under section 1871 of the Social Security Act and cannot be applied. Rather, at most, the policy articulated in the 2009 Final Rule focuses on the use of "case-specific evidence" to provide "a fuller picture of the program" and deny treatment as a new program to a program that "has literally been moved in its entirety from one hospital to another, and is accredited as 'new' in the second hospital." 74 Fed. Reg. at 43,913. Nowhere in the 2009 Final Rule does CMS suggest an "overwhelming majority" standard or other such rigid criteria that would exclude new programs that include some residents with prior training. In order to minimize inappropriate denials based on sub-regulatory newness criteria properly abandoned under the proposed policy and the burden of subsequent appeals that may take many years to resolve, FAH requests that CMS provide instructions to its MACs confirming that a program established before October 1, 2026 will still be treated as new as of the date it receives accreditation or begins training as long as the program was not moved in its entirety from one hospital to another.

Lastly, FAH suggests the following non-substantive revisions to the regulatory text to move the effective date for the additional conditions to the introductory paragraph of § 413.79(*l*):

> (l) For purposes of this section, a new medical residency training program means a program that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995, and**, in the case of a medical residency training program that receives such initial accreditation or begins training residents on or after October 1, 2026,** that meets the following additional conditions:
>
> (1) Subject to the provisions of paragraphs (l)(2) and (l)(3) of this section, ~~**effective for programs started on or after October 1, 2026,**~~ . . . .

We believe that these drafting changes more closely hew the proposed regulatory text to the proposed policy and avoid any unintended ambiguities with respect to programs that started prior to October 1, 2026.

VIII. Reasonable Cost Payment for Nursing and Allied Health Education (Part V.G)

Background

Hospitals may receive reasonable cost payment for Medicare's share of a hospital's costs for provider operated nursing and allied health (NAH) education payments. 42 CFR §413.85(d)(2)(i) indicates that:

The net cost of approved educational activities is determined by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs

Under 42 CFR §413.24, hospitals allocate indirect costs to each direct cost center through the step-down method:

Step-down method. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue.[25]

In the FY 2026 IPPS proposed rule, CMS proposed that tuition, student fees, textbooks purchased for resale and other revenue from or on behalf of students is subtracted before completing the indirect cost allocation. FAH opposed CMS' proposal to change the order of operations for the indirect cost allocation as it would have conflicted with the purpose of the indirect cost allocation. The indirect cost allocation assigns administrative and general costs that support the entire institution to each direct cost center on the Medicare cost report. Using the step-down process, indirect costs are allocated to each direct cost center in relationship to how that direct cost center is supported by administrative and general costs.

FAH was not the only commenter opposed to CMS' proposal. CMS received many comments objecting that its proposed policy was inconsistent with general cost-finding principles and would result in the NAH education cost centers receiving less than their share of institutional overhead. Due to the number and nature of the comments, CMS decided not to finalize the proposed changes and said it expects to revisit the treatment of NAH education costs in future rulemaking.

Rulemaking Issues:

After considering the public comments on the proposal in the FY 2026 IPPS proposed rule, CMS continues to believe that correct accounting procedures require the deduction of tuition and other revenue from the direct costs of a provider's approved educational activities prior to the allocation of overhead. However, CMS is modifying its original proposal to ensure that the deduction of revenue does not inappropriately reduce the allocation of overhead to the NAH cost centers when hospitals allocate administrative and general costs using accumulated cost as the default statistical basis. CMS is also proposing to clarify the nature of allowable indirect costs of approved educational activities and to refine the cost reporting procedures to ensure that hospitals appropriately allocate overhead costs to the NAH cost centers.

Worksheet A is where hospitals accumulate direct costs while Worksheet B is where the indirect cost allocation is done. CMS' proposals involve subtracting revenues a hospital receives from tuition, student fees, textbooks purchased for resale and other revenues on Worksheet A-8 of the Medicare cost report. Those revenues would then be added to NAH costs on Worksheet B-1 only for purposes of the overhead allocation. The proposed rule indicates that this procedure would result in the NAH cost center receiving its share of administrative and general expenses in the indirect allocation without NAH costs being used in subsequent steps of the indirect cost allocation that allocate costs for non-patient care cost centers like NAH to other patient care cost centers on the Medicare cost report.

CMS states this procedure is consistent with other non-patient cost centers like interest expense and cafeteria which have adjusted costs respectively for investment revenue and revenue from the sale of food and beverages before the shares of expenses in these non-patient care costs are allocated to patient care cost centers.

FAH agrees with CMS' first proposal regarding allocation of indirect costs to the nursing and allied health education cost center as it would result in the appropriate allocation of indirect costs to the nursing and allied health education cost center and all other cost center among which indirect costs are allocated. Once again, FAH is pleased that CMS listened to the comments that FAH and others made on CMS' FY 2026 IPPS rule and adopted a proposed policy consistent with those comments.

The second proposal clarifies that indirect costs may only be allocated to the NAH education cost center to the extent those costs benefit the hospital's nursing and allied health education programs. For this purpose, CMS is proposing to

require providers with approved NAH education program componentize—fragment or subscript—their general service cost center as follows:

- Indirect costs that provide a benefit to the hospital's NAH programs, and
- Indirect costs that do not provide a benefit to NAH.

Only those indirect costs that provide a benefit to the hospital's NAH would be allocated through the indirect cost allocation to the NAH cost center to be reimbursed reasonable costs. Costs in the second category would be deleted from the indirect cost allocation so that those costs are allocated to the departments that they serve but not to the NAH cost centers. Further, as the regulations prohibit a hospital from receiving reasonable cost payment for related party costs (such as a home office), the provider would have to further distinguish between administrative costs incurred directly by the hospital and a related party. CMS notes that the componentization of general service cost centers is consistent with longstanding Medicare cost reporting procedures as described in the Provider Reimbursement Manual (CMS Pub. 15-1, chapter 23, section 2307(B)).

FAH disagrees with CMS' second proposal regarding the allocation of indirect costs. To be considered an indirect cost, the cost cannot be attributed to any individual cost center. If a cost can be attributed to an individual cost center, it is, by definition, a direct cost, not an indirect cost. 42 CFR §413.24 authorizes use of the step-down process for allocating indirect costs to each of the direct cost centers. Using the step-down process, indirect costs are allocated to each direct cost center in relationship to how that direct cost center is supported by administrative and general costs.

CMS' longstanding policy has recognized the step-down method of apportioning indirect costs under 42 CFR §413.24. This allocation method has been longstanding and recognizes that a revenue producing cost center like nursing and allied health education is supported by administrative and general expenses of the hospital such as utilities, rent, administrative salaries, and depreciation as noted in CMS' cost finding principles:

For the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers should include both its direct expenses and its proportionate share of the costs of each nonrevenue-producing center (indirect costs) based on the amount of services received.[26]

By using direct expenses in the step-down method, the nursing and allied health education cost center draws "a proportionate share" of indirect expenses that are supporting the hospital's nursing and allied health education activities. For these reasons, **FAH requests that CMS not finalize its proposal to componentize—fragment or subscript—the general service cost center between those costs that provide a benefit to the hospital's NAH programs and other indirect costs as such a proposal ignores that indirect costs cannot be attributable to any direct cost center and CMS' proposal is inconsistent with longstanding cost reporting principles.**

As it did in the FY 2026 IPPS proposed rule, CMS again indicates that the cost of a related organization such as a home office would not be an allowable indirect cost that could be allocated as part of the indirect cost allocation. However, long-standing CMS policy has recognized that home office costs are an allowable cost for the indirect cost allocation. Publication 15-2, PRM Chapter 40, section 4017 states:

> Cost applicable to home office costs, services, facilities, and supplies furnished by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost-conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.[27]

The PRM recognizes that the costs of a home office are legitimate costs to a hospital if those costs are not inflated in the transaction. In these circumstances, the related organization is a home office or other related organization with the sole purpose of furnishing allowable cost services to a hospital or another hospital in its network. A home office is not a "related organization. It is an integral part of the hospital (or hospitals) when it functions solely to provide administrative support services to a network of hospitals under common ownership.

CMS' policies would create two inconsistencies if a home office's costs cannot be allocated to the nursing and allied health education cost center. First, CMS would be treating an administrative portion of the hospital differently when it is part of the hospital serving one or more hospitals than if it were freestanding and apart from its patient care units. In the former circumstance, CMS' policy would be clear that the administrative portion of the hospital would be supporting the remainder of the institution and its costs could be allocated to all direct cost centers on the Medicare cost report while

in the latter, CMS is distinguishing the administrative portion of the hospital as a related organization even though it is functioning in the exact same capacity as the former.

Second, CMS would allow home office costs to be allocated to all direct cost centers in both circumstances through the step-down method—except nursing and allied health education, based on related-party concerns. There is no valid basis for treating home office costs for nursing and allied health education differently from those for other direct cost centers, especially because the PRM clearly states that home office costs are allowable in the indirect cost allocation and CMS has long recognized them as allowable for reasonable cost reimbursement across all cost centers.

FAH requests CMS not finalize its proposal that home office costs are not an indirect cost that can be allocated to the nursing allied health education cost center when the home office is not an educational institution. In the January 12, 2001 final rule, CMS indicates that the concern motivating the disallowance of related costs track to the original statute creating Medicare: "it was not intended that Medicare should pay for increased costs resulting from a redistribution of cost from educational institutions to providers."[28] However, long-standing CMS policy has recognized the legitimacy of home office costs that are not associated with an educational institution.

There is no risk of redistribution of costs from an educational institution to a hospital when a home office is only providing necessary administrative services and not supporting an educational infrastructure. In these circumstances, the home office's sole purpose is furnishing allowable cost services to a hospital or another hospital in its network. **FAH opposes CMS' proposal related to home office costs because it would treat nursing and allied health education differently than all other cost centers for purposes of the indirect cost allocation.**

IX. Hospital Readmissions Reduction Program (HRRP) (Part V.I)

Proposed Adoption of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization Measure (Part V.I.2.b)

CMS proposes to add the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization (Sepsis Readmission) measure to the measure set, with a phased approach that would use "early look" reports for FY 2028 before the measure begins to be used in the FY 2029 payment adjustment.

The proposed sepsis readmission measure integrates Medicare Advantage (MA) beneficiary data and reduces the performance period from three years to two years. It also includes the technical change involving updating the risk adjustment model to use individual ICD- 10 codes instead of Hierarchical Condition Categories (HCCs). CMS states that this change is considered non-substantive and would improve the performance of the risk adjustment models for condition- and procedure-specific mortality and other measures.

FAH does not support this measure, as refined to include MA beneficiary data in this measure set for purposes of payment reduction. If CMS proceeds despite our objections noted below, we ask for a delay by at least one year. Because CMS did not provide an impact analysis for the proposed change, FAH worked with McDermott, Will & Emery (McDermott+) to model the potential effects of CMS's proposed changes in the FY 2026 IPPS proposed rule. M+'s analysis demonstrated that CMS's proposed inclusion of MA patients would increase HRRP penalties even when hospital performance did not change.

Using FY 2025 excess readmission ratios, hospital characteristics, neutrality modifiers, and MA "shadow claims" from Medicare Provider Analysis and Review (MedPAR), McDermott+ modeled the effect of adding MA patients to the DRG ratio calculation. In a scenario modeling a three-year performance period, aggregate penalties increased by $41 million; when the performance period was shortened to two years, penalties increased by $46 million. These increases occurred largely because hospitals already subject to HRRP penalties saw those penalties grow under the revised methodology.

The McDermott+ analysis confirms that the proposal broadens the penalty base rather than simply improving measure accuracy. HRRP is designed to assess excess readmissions as a percentage of base operating DRG payments under the inpatient PPS. By incorporating MA patients into the DRG ratio calculation, CMS effectively assumes that MA and fee-for-service beneficiaries are interchangeable for penalty purposes, even though hospitals are paid differently under MA and MA plans frequently use separate utilization management and post-acute care restrictions.

Hospitals have not yet had sufficient opportunity to evaluate performance under the measures finalized through last year's rulemaking cycle. Providing at least two full years of performance data would allow hospitals to better understand how each change affects measure performance and potential penalty exposure. FAH also requests that CMS release

the model specifications in advance to enable hospitals to develop appropriate internal monitoring and analytic tools. We reiterate our overarching concerns with these changes below.

Inappropriate Integration of MA Data into Legacy Medicare Penalty Programs

The integration of MA beneficiary data into the HRRP measure set is fundamentally flawed and risks creating a distorted and inequitable penalty structure for hospitals. Traditional Medicare uses a narrowly defined, condition-specific penalty program to incentivize hospitals to reduce readmissions, applying financial withholds tied to clinically validated cohorts. In contrast, the MA program uses an All-Cause Readmissions measure to determine plan Star Ratings—an upside-only system in which MA plans face no financial loss for poor performance, only the potential for increased bonus payments.

These are two entirely different accountability structures: one imposes penalties on hospitals, while the other rewards health plans. Blending data from a provider-facing penalty system with data from a plan-based reward system is methodologically inappropriate and misaligned. It is not equitable to subject hospitals to penalties based on data derived from a system where plans are not similarly accountable.

Data Source Integrity and Transparency

FAH is deeply concerned by CMS' anticipated reliance on MA encounter data rather than paid claims to calculate hospital performance scores and opposes CMS's approach to include MA data in the HRRP measures. Unlike traditional Medicare fee-for-service claims processing, where hospitals and CMS can evaluate both submitted claims (837 transactions) and adjudicated remittance data (835 transactions) to determine whether a claim was paid, denied, or adjusted and for what reason, MA encounter data submitted to CMS lacks comparable transparency and adjudication detail.

CMS has not clarified whether a given claim included in the dataset was paid, denied, or denied for administrative versus clinical reasons. Many MA plans employ automated processes that deny readmissions solely based on proximity to the original discharge date, without regard for clinical necessity. This practice undermines the integrity of any readmissions data derived from MA encounter submissions. Additionally, denied claims with clinical relevance may not appear in encounter data unless they support risk adjustment. Plans may selectively report such claims for their benefit while omitting them from reporting mechanisms affecting hospital penalties. CMS must clarify which data elements it intends to use and whether hospital readmission scores under HRRP will be accompanied by plan-specific subsets or flags.

Further complicating matters, MA plans often delegate claims processing to downstream entities, creating risks for inaccurate data transfer, inconsistent file submissions, and unclear accountability. These inconsistencies directly affect hospital performance scores under HRRP and the Hospital Value-Based Purchasing (HVBP) program. CMS must require attestation of data accuracy from MA plans and establish a transparent process to address disputes when hospitals are held responsible for errors beyond their control.

Many of the same MS-DRGs implicated in HRRP are also used in HVBP's mortality and complication measures, including the sepsis measure. Hospitals are incentivized to implement early recognition protocols for sepsis and can be rewarded for strong performance. However, MA plans often deny or down-code sepsis-related admissions, citing non-standardized criteria or inconsistent definitions.

This practice creates a troubling contradiction: hospitals may be penalized or denied reimbursement under MA contracts while being held accountable by CMS for performance on the same clinical episodes. It is unclear how CMS plans to reconcile conflicting interpretations of care delivery or ensure that encounter data reflect the full scope and clinical integrity of a hospital's interventions. We are very concerned that these same inconsistencies will occur with this new readmission measure for sepsis hospitalizations.

Risk Adjustment Shift to ICD-10 and Data Volatility

FAH also continues to strongly oppose the shift from HCCs to ICD-10 codes. This change is not a minor technical refinement. It marks a foundational departure from the risk adjustment methodology currently in use across multiple CMS programs, including the CMMI TEAM model, which continues to rely on HCCs. Hospitals have made significant investments to support accurate HCC coding and reporting as part of quality and compliance operations. Abruptly shifting to ICD-10 codes without adequate transition time, training, or validation creates substantial operational risk and

threatens the continuity of data integrity. Implementing this change alongside other significant updates, including adding MA beneficiaries and the shortened performance period, exacerbates the hospital burden and introduces uncertainty that may undermine quality improvement efforts.

FAH also opposes the proposed reduction in the HRRP performance period from three years to two. This policy was originally used in the early years of the HRRP and was found to produce volatile results. The shift to a three-year period was made to improve reliability and predictability in performance assessments. CMS has not provided evidence that the concerns previously associated with two-year periods have been resolved. In addition, we are very concerned to see the minimum measure reliability was 0.205 across the more than 3,000 facilities with at least 25 admissions. That result underscores the risk of adopting a measure that is not yet sufficiently stable for payment use. In a program as consequential as HRRP, CMS should not finalize a new measure until it can demonstrate that the measure is sufficiently reliable, transparent, and operationally workable.

These proposals collectively reflect a broader pattern of CMS implementing significant programmatic changes too rapidly and without sufficient transparency. **For these reasons, FAH urges CMS to postpone use of the proposed sepsis readmission measure in payment determinations, provide the complete technical specifications in advance, and allow hospitals at least two full years of data under the final methodology before any penalty is applied. CMS should not move forward until it has demonstrated that the redesigned measure is fair, reproducible, and capable of distinguishing true quality performance from methodological noise.**

X. Hospital Value-Based Purchasing Program (HVBP) (Part V.J)

Proposed Adoption of Modified Mortality Measures into the Hospital Value-Based Purchasing Program (Part V.J.2.b)

CMS proposes to adopt substantive measure updates to five condition-specific and procedure-specific mortality measures, in the Clinical Outcome domain, beginning with the July 1, 2028, through June 30, 2030, performance period for the FY 2032 program year, contingent on adopting these same changes in the Hospital IQR Program.

FAH remains concerned for two primary reasons: the timing of these substantive proposed changes and the lack of timely transparency regarding the underlying model specifications. Hospitals require sufficient detail on the methodology to assess the potential impact on performance scores, validate the calculations, and implement meaningful quality improvement activities for patients. **Accordingly, FAH does not support incorporating these updated measures into the Hospital VBP Program until hospitals have had adequate time and data to evaluate the effects of the revised methodology and operationalize targeted improvement efforts.** FAH's comments on the individual measures are discussed further in the Hospital IQR Program section below.

XI. Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2027 (Part VIII)

FAH joined with the American Hospital Association (AHA), the National Association of Long-Term Hospitals (NALTH) and the Coalition of Long-Term Acute Hospitals to press for meaningful reform of the LTCH payment system. In March 2026, we jointly released a set of LTCH Reform Policy Principles urging Congress and the administration to act to stabilize the LTCH sector and provide critical relief to LTCHs and the patients they serve.[29] The coalition's joint analysis of publicly available Medicare data showed that since the dual-rate system took effect in 2016, cumulative Medicare FFS LTCH spending has fallen by roughly $11 billion, far exceeding the $3 billion CBO projected over ten years. Annual LTCH spending is now approximately 45 percent lower than pre-dual rate levels, and more than one in four LTCHs has closed in the last decade. Against that backdrop, the policies proposed in this year's rule have significant implications for the LTCH community. FAH supports legislative reform where congressional action is required and urges CMS to take administrative action now in the areas where it has existing statutory authority to do so.

LTCH Reform Principles

FAH urges CMS to evaluate the proposals in this rule against the coalition's reform framework. That framework reflects a shared, cross-industry view of what it will take to stabilize the LTCH sector. The principles are:

- **Ensure access for high-acuity beneficiaries.** The current dual-rate structure excludes many of the clinically complex patients LTCHs are designed to treat. Payment eligibility criteria should be expanded so that reimbursement reaches the patients who need LTCH-level care.

- **Improve the accuracy of the LTCH PPS.** LTCHs have been persistently underpaid relative to the cost of the patients they treat. The system should be modernized, including through updated DRG weighting and inflation updates that reflect actual LTCH cost growth.
- **Modify the 25-day average length of stay requirement.** The 25-day standard predates four decades of clinical change and no longer reflects how quickly many patients can be treated. The requirement and its calculation should be updated to match current clinical practice.
- **Restructure the LTCH outlier system.** LTCHs treat some of the highest-cost patients in Medicare, and outlier payments are essential to their stability. As volumes have fallen and the fixed-loss amount has climbed, LTCHs absorb tens of thousands of dollars in losses before any outlier payment applies. The outlier system should be restructured to restore meaningful protection for high-cost cases.
- **Expand rural access to LTCHs.** Rural beneficiaries are too often cut off from LTCH-level care by the dual-rate structure. Criteria should be updated so that patients can qualify for full LTCH payment regardless of where they live.
- **Rein in harmful Medicare Advantage (MA) practices.** As MA enrollment grows, plans increasingly use prior authorization and network restrictions to limit access to LTCH care. MA plans should be required to provide timely access to medically necessary LTCH services.

Several of these principles require legislation, and FAH is working with Congress to urge action. But three are squarely within CMS's existing authority and can be advanced in this rulemaking cycle: improving payment accuracy, restructuring the high-cost outlier system, and modifying the calculation of the 25-day ALOS requirement. FAH urges CMS to use the administrative tools it already has, beginning with the items below, while legislative reform proceeds.

25-Day Average Length of Stay (Part VIII.A)

FAH urges CMS to use its existing administrative authority to modify the methodology for calculating the 25-day average length of stay (ALOS) requirement that defines LTCH status. **Specifically, FAH recommends that CMS exclude short-stay outlier (SSO) cases discharged to hospice or who expire in the LTCH from the ALOS calculation.** This change does not require congressional action, as the statute grants the Secretary broad discretion in how ALOS is determined.

Legal authority for this approach is well established. In the FY 2003 LTCH PPS Final Rule, the Secretary expressly exercised broad discretion in determining how to calculate ALOS for LTCH classification purposes. CMS has the authority to revisit that calculation methodology administratively, without legislation, provided the change is made through notice-and-comment rulemaking.

SSO cases discharged to hospice or who expire in the LTCH are categorically different from other LTCH discharges. These patients did not leave because they recovered faster than average; they passed away or transitioned to hospice care. Including their shorter stays in the ALOS denominator artificially depresses the facility-level average in ways that reflect patient severity and clinical trajectory, not clinical decision making. The current methodology penalizes LTCHs for accepting the highest-acuity patients, and removing these cases from the ALOS calculation is methodologically sound, not a regulatory workaround.

This modification is designed to be targeted. The cases that currently qualify for full LTCH payment on clinical grounds would, by and large, continue to meet the criteria. What changes is that the denominator would no longer be artificially depressed by discharges that are a function of patient mix, not of average treatment duration. **FAH requests that CMS include a proposal to modify the ALOS calculation methodology in future rulemaking or through a dedicated Request for Information. In the interim, FAH looks forward to engaging with CMS on implementation details.**

XII. Proposed Changes to the Payment Rates for the LTCH PPS for FY 2027 (Addendum Part V)

Proposed Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases (Part V.C)

FAH supports CMS's proposal to freeze the FY 2027 LTCH HCO fixed-loss amount at $78,936, unchanged from FY 2026. The decision to hold the threshold constant rather than allow it to rise under the current methodology reflects an appropriate acknowledgment of the uncertainty in that methodology, and FAH appreciates CMS's responsiveness to provider concerns. That said, FAH urges CMS to go further. The fixed-loss threshold functions like a deductible layered on top of the MS-LTC-DRG payment. At the current fixed-loss amount, a hospital must absorb a staggering $78,936 in costs above the MS-LTC-DRG payment rate before *additional* excess costs are partially defrayed through

HCO payments. For example, if the costs of a case exceed the MS-LTC-DRG payment amount by $150,000, this fixed-loss threshold leaves the hospital with a *total loss of $93,149* on the case *after* HCO payments.

The freeze preserves a threshold that is already approximately three times the historical norm, the product of a methodological shift CMS made in FY 2022 without an adequate administrative record and data. Starting in FY 2022, CMS switched from a market basket-based charge inflation factor approach to one driven by actual charge growth, dramatically increasing the fixed-loss threshold and leaving it at a level that effectively prices most extraordinary-cost cases out of the HCO payment system. The resulting problems can be seen in the astronomical growth of the threshold: in just two years, from FY 2023 to FY 2025, the HCO fixed-loss threshold for the LTCH PPS doubled. Freezing the threshold is a step in the right direction; returning to a sound methodology is the necessary one. At its current level, the threshold harms LTCH providers, the beneficiaries who depend on them, and the referring hospitals that rely on LTCH capacity for their highest-acuity patients.

FAH urges CMS return to the market basket-based charge inflation factor methodology that governed HCO threshold calculations prior to FY 2022. Under that methodology, joint coalition analysis estimates that the FY 2026 threshold would have been approximately $51,000, roughly $28,000 lower than what CMS finalized. **FAH requests that CMS cap the threshold at that level with no budget neutrality adjustment.** CMS has stated that LTCH PPS budget neutrality applies only to FY 2003, the first year of implementation. The gap between the current threshold and the prior-methodology equivalent directly reduces the outlier payments for the sickest and most complex LTCH patients, the exact population the care setting exists to serve.

Moreover, FAH again urges CMS to closely evaluate the scope of its regulatory authority to address the fundamental rate setting issues that are causing the costs of so many LTCH cases to exceed payment under the LTCH PPS, and also to work with Congress to ensure that rates are sufficient to retain LTCHs as a critical component of the health care delivery system. In addition, as discussed further below, FAH urges CMS to account for anticipated LTCH outlier reconciliation recoupments when calculating the HCO fixed-loss amount for the LTCH PPS, in the same manner that CMS currently accounts for IPPS outlier reconciliation recoupments when setting the IPPS outlier fixed-loss threshold.

Outlier Reconciliation: Change Requests 13566 and 14233 (Part V.C)

FAH urges CMS to rescind Change Requests 13566 and 14233. Before CR 13566 and CR 14233, the HCO reconciliation process applied to roughly 2 percent of LTCHs annually. By shifting the trigger from a 10-percentage-point absolute CCR difference to a 20 percent relative difference, the policy adopted in these change requests expanded that universe of LTCH's undergoing HCO reconciliation to approximately 24 percent. Providers that would not have been subject to reconciliation under the prior standard are now subject to reconciliation and recoupment.

CR 13566 carried out a significant change in CMS policy, with significant financial consequences for IPPS and LTCH PPS providers. But this change to the substantive legal standards governing payment for services was adopted without notice-and-comment rulemaking and without the benefit of an assessment of regulatory burdens and economic impacts. In short, the concerns that drove the policy change could only be addressed through rulemaking, not a transmittal.

FAH urges CMS to rescind Change Requests 13566 and 14233, which revised the reconciliation criteria without notice-and-comment rulemaking. Rescission of these transmittals is necessary to reverse changes to the substantive legal standards governing payment for IPPS and LTCH services, which can only be adopted through notice-and-comment rulemaking under section 1871 of the Social Security Act. If and when CMS undertakes rulemaking on this issue, FAH recommends that CMS update the $500,000 minimum outlier payment threshold embedded in the reconciliation criteria. That figure was established in 2002, has never been adjusted for inflation, and would be roughly $900,000 today. Leaving a 24-year-old nominal threshold in place while tightening the CCR-based trigger captures providers the original policy was not designed to reach.

In the alternative, if CMS declines to rescind the change requests, at a minimum, FAH urges CMS to revise its HCO fixed-loss amount calculation methodology for the LTCH PPS to account for reconciliation. CMS calibrates the fixed-loss threshold to produce HCO spending equal to approximately 7.96 percent of total LTCH PPS payments. A model targeting that share must reflect the full payment cycle, including expected recoupment at settlement, to produce a threshold that achieves the target on a net rather than a gross basis. With 24 percent of LTCHs now falling under the expanded reconciliation criteria, a materially larger share of gross HCO payments will likely be recovered at settlement, and a model calibrated to the historical reconciliation rate will fall short of its target on a net basis.

XIII. Crosscutting Quality Program Proposals and Requests for Comment (Part IX.B)

Proposed Adoption of the Advance Care Planning Electronic Clinical Quality Measure (eCQM) in the Hospital IQR, PPS-Exempt Cancer Hospital Quality Reporting, and Medicare Promoting Interoperability Programs (Part IX.B.1)

CMS proposes to adopt the Advance Care Planning eCQM in the Hospital IQR, PPS-Exempt Cancer Hospital Quality Reporting, and Medicare Promoting Interoperability Programs. CMS proposes, for the IQR and Medicare Promoting Interoperability Program, to adopt the eCQM as part of the eCQM measure set, from which a hospital can self-select measures to report to meet the eCQM reporting requirement, beginning with the CY 2028 reporting period/FY 2030 payment determination. For the PCH QRP, CMS proposes to adopt the eCQM beginning with the CY 2028 reporting period/FY 2030 program year.

FAH supports patient-centered care and recognizes that advance care planning is an important component of high-quality care across the continuum. **However, we believe that this measure has not been sufficiently tested to ensure that hospitals can capture the required data in a reliable and valid manner.** Specifically, data element validity was only evaluated in one electronic health record system (EHR), and feasibility was assessed in 2 EHRs. Based on hospitals' experiences with the data elements required for the Hybrid Hospital-Wide All-Cause Readmission measure, we know that this testing is insufficient and does not provide information to ensure that the required data can be captured through existing workflows.

There is also a real risk that hospitals will not have enough time to complete the additional mapping and education required to successfully capture the data if reporting begins with the CY 2028 reporting period. The numerator requirements for this measure are complex, and implementation will need to comply with any individual state requirements. This eCQM should also ensure that an individual's religious and/or cultural beliefs can be honored; specifically, the measure should include an exception or guidance allowing the documentation of a discussion to account for those individuals for whom the conversation would be forbidden.

We believe that CMS should modify the measure to address this important patient-centered concern and complete additional testing across more EHRs and hospitals of varying size, location, and ownership before the measure is finalized for any program. If CMS chooses to move forward with the measure as currently specified and tested, we request that hospitals be given at least 18 months to prepare to report the measure followed by two years of voluntary reporting prior to any mandatory use.

Proposed Adoption and Modifications to Five Mortality Measures in the Hospital IQR Program and HVBP (Part IX.B.2)

CMS proposes modifications to five condition-specific and procedure-specific mortality measures beginning with the FY 2032 program year including:

1. Expanding to include MA patients
2. Reducing the performance period from three years to two years
3. Updating the risk adjustment model to use individual ICD-10 codes instead of HCCs

We reiterate our concerns on the timing of these changes and need for immediate transparency of the model specifications. Hospitals must have these details to understand the potential impact to their performance scores and enable them to continue to drive quality improvement to their patients.

In addition, FAH is concerned that 25% of hospitals did not achieve reliability above 0.6 with at least 25 cases specifically for the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization measure. We believe that these results confirm our concerns that measure reliability cannot be preserved, using the shortened two-year timeframe. We also note that none of the mortality measures had testing of social risk factors in the risk adjustment model completed nor was there any justification for this omission.

FAH believes that it is critical for developers to continue to complete these analyses to understand the degree to which any one factor may sufficiently impact a hospital's performance score and may justify its inclusion in the model in the future. This testing should be completed before these revised measures are finalized for use in HVBP.

Request for Information: Measuring Emergency Care Access and Timeliness in the Hospital IQR Program and HVBP
CMS requests comments on the potential use of the Emergency Care Access and Timeliness eCQM in the Hospital IQR Program and HVBP (Part IX.B.3)

FAH does not support including this measure in the Hospital IQR Program or HVBP. Hospitals are just becoming familiar with reporting these data from EHRs as required in the Hospital Outpatient Quality Reporting (OQR) Program, and it is too soon to consider this eCQM for other programs. In addition, we question the utility of having the same measure in the Hospital IQR and OQR Programs.

Request for Information: Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the Hospital IQR Program (Part IX.B.4)

CMS requests comment on the potential future use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the Hospital IQR Program. FAH supports continued efforts to address the significant clinical impact of sepsis and, in general, does not have concerns with the measure itself.

However, FAH urges CMS to proceed cautiously before incorporating this measure into a CMS quality program and to allow hospitals sufficient time to operationalize reporting using the Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standard. As stated in prior comment letters, we support the transition to digital data but considering the challenges with collecting these data that were discovered during the implementation of the hybrid measures, hospitals face many challenges collecting these data already and we do not believe that every facility is ready to rapidly move to leveraging FHIR.

We continue to encourage CMS to establish a clear glidepath that outlines the essential steps, stakeholders, and milestones required for successful FHIR digital quality measure (dQM) implementation. It should include widespread testing across multiple vendors and systems to ensure that the required data can be collected, and any rapid proposals to use FHIR dQMs in any penalty program should be avoided.

XIV. Hospital Inpatient Quality Reporting (IQR) Program (Part IX.C)

The Federation reiterates its position that the Hospital-Level Total Hip Arthroplasty / Total Knee Arthroplasty Patient-Reported Outcome Performance Measure (THA/TKA PRO-PM) should not carry negative payment adjustments in the IQR program, should be removed from the TEAM model, as well as from consideration for the proposed CJR-X model or any other CMS program until a fundamental redesign is completed and validated. The measure, in its current form, imposes an extraordinary data-collection burden on hospitals and patients, lacks foundational design safeguards, and has demonstrated systemic implementation failures that undermine the objectives of value-based care.

Evidence from CMS and independent analyses demonstrates the core flaws of the THA/TKA PRO-PM as currently configured. CMS data released February 25, 2026, show that roughly 60 percent of the 111 hospitals that voluntarily reported the measure failed to meet the 50 percent sample-size requirement and achieve a score. Reporting success was disproportionately concentrated among larger urban teaching hospitals with more than 200 beds, while smaller, rural, and medically underserved facilities were systematically unable to achieve a score, not because of care quality, but because of the measure's design characteristics.

The Lewin Group's Performance Year 7 Safety-Net Hospital Experiences report corroborates that safety-net hospitals operate with lower volumes, higher fracture concentrations, and substantially different patient populations than non-safety-net institutions. These realities are precisely the operational factors that determine whether a hospital can meet the THA/TKA PRO-PM's thresholds. If the measure is mandated across programs, these disparities would likely be entrenched and amplified, rather than addressed, undermining the programs' goals that CMS seeks to advance.

The measure's structural deficiencies are numerous and substantial. It contains no case minimum, and the 50 percent response-rate requirement imposes an unrealistic and disproportionate burden, particularly on low-volume and rural hospitals from the outset. The timing and volume of data collection have never been adequately tested from the patient's perspective, leading to misalignment with real-world workflows and administrative capabilities. Hospitals cannot exclude patients who actively decline to participate or those who transition from outpatient to inpatient status unexpectedly, yet penalties are levied on patient choices rather than on care quality.

The denominator cannot be limited to patients for whom Medicare is the primary payer, and the pre-operative data collection requirement compounds burden in ways that undermine any realistic possibility of attaining a 50 percent threshold over the lengthy post-operative period. Post-discharge follow-up often occurs through the surgeon's practice rather than the hospital, further eroding hospital-based engagement and survey response rates. In short, the measure as designed does not reflect the operational realities faced by many hospitals, particularly those serving vulnerable

populations in rural and safety-net contexts, and it creates a disproportionate risk of penalties without corresponding accountability for care quality.

Operational realities further undercut feasibility. Rural settings frequently lack reliable bandwidth and integrated data systems, complicating data capture and timely reporting. The involvement of non-employed providers and multiple, non-integrated EMR systems increases data-validation burdens and delays. Hospitals must absorb the costs and workload of pre-operative data collection, patient outreach, and post-operative follow-up across diverse provider environments, which often operate independently from hospital-based processes. The result is a misalignment between the measure's requirements and the practical workflows that govern patient care and data gathering in many settings, particularly those serving high proportions of uninsured or underinsured patients.

Given these findings, continuing to impose negative payment adjustments for this THA/TKA PRO-PM within IQR, TEAM, or any mandatory CMS model would be inappropriate and counterproductive. CMS should promptly remove any IQR penalties tied to the Hospital-Level THA/TKA PRO-PM, revise the measure, ensure the measure has been tested across diverse hospital settings, and produce a measure that is scientifically sound and operationally feasible. Any revised THA/TKA PRO-PM should incorporate an appropriate case minimum, e.g. 10 for small and/or rural hospitals and 25 for larger, urban hospitals, a feasible data-collection framework with an evidence-based response rate less than 50% that is realistic for low-volume and rural settings, meaningful patient-exclusion criteria (including explicit opt-out provisions when patients decline to participate or are in hospice), and clinically realistic data-collection timelines that align with everyday clinical workflows.

The Federation urges CMS to remove the current penalties associated with the measure in the IQR program, proceed with a comprehensive redesign of the measure, and exclude it from mandatory use in the TEAM model and in the proposed CJR-X model. The Federation remains prepared to collaborate with CMS to redesign a measure that accurately reflects care quality, supports hospitals across the full spectrum of settings, and avoids punitive consequences driven by fundamental design flaws rather than true performance.

Proposed Adoption of Excess Days in Acute Care After Hospitalization for Diabetes (Diabetes EDAC) Measure (Part IX.C.3.a)

CMS proposes to adopt the Diabetes EDAC measure beginning with the July 1, 2025, through June 30, 2027, performance period, associated with the FY 2029 payment determination.

CMS proposes to adopt the Diabetes EDAC measure with two features warranting separate attention: inclusion of Medicare Advantage beneficiaries in the cohort and a 2-year performance period. **FAH opposes both features for this measure and reiterates our overarching concerns about transparency and timing.** Unlike a readmission measure, Diabetes EDAC counts days across ED visits, observation stays, and unplanned readmissions — making it uniquely sensitive to the MA encounter data integrity problems detailed in our HRRP comments above, since MA plans report ED and observation encounters inconsistently and through downstream entities. The 2-year window compounds this exposure for hospitals with smaller diabetes volumes. While CMS tested dual-eligible status and found minimal impact, that single-variable analysis does not substitute for broader social risk factor evaluation in a chronic-disease population whose post-discharge utilization is heavily driven by outpatient access, caregiver support, and medication adherence — factors outside inpatient hospital control.

FAH does not support the inclusion of this measure into the IQR program and urges CMS to delay adoption of the Diabetes EDAC measure by at least one year. We urge CMS to release full model specifications immediately so hospitals can assess performance impact, develop internal monitoring tools, and engage in meaningful quality improvement before the measure is implemented.

Proposed Adoption of the Hospital Harm – Postoperative Venous Thromboembolism eCQM (Part IX.C.3.b)

CMS proposes to adopt the Hospital Harm – Postoperative Venous Thromboembolism eCQM as an eCQM option for hospital selection beginning with the CY 2028 reporting period/FY 2030 payment determination. Mandatory reporting of this eCQM would begin with the 2030 reporting period/FY 2032 payment determination. **FAH believes that there is a lack of evidence to support the inclusion of the presence of this complication in the 30 days after discharge. This same concern was discussed during the Pre-Rulemaking Measure Review (PRMR) process.**

The developer has not provided any studies supporting the extension nor did the conceptual model provided during the PRMR review acknowledge that the outcome would be captured beyond discharge. CMS must demonstrate that the

occurrence of a VTE post-discharge is directly linked to the care received during the inpatient stay and ensure that the data for the post-discharge event can be captured.

FAH does not believe that this specific data element was sufficiently evaluated during data element validity testing. Data element validity testing was limited to two vendor systems, which is insufficient to ensure that the measure specifications are aligned with clinical workflows, and it was not clear if the testing evaluated data post-discharge. Based on hospitals' experiences with data derived from EHRs, we would assume that there could be a higher degree of missing data for these events since the sole data source for the measure is EHRs and it is extremely difficult for hospitals to track events after discharge.

Since this measure tracks the outcome 30 days after discharged, we would expect to see testing of social risk factors in the risk adjustment model; however, this information was not provided nor was there any discussion of these variables' potential effect in the conceptual model. FAH believes that the risk models for outcome measures that extend across settings must continue to include these factors in testing since it is important to understand the degree to which any of one factor may sufficiently impact a hospital's performance score and may justify its inclusion in the model.

FAH recommends that CMS address the lack of evidence to support the 30-day post-discharge timeframe and complete additional testing across more EHRs and hospitals of varying size, location, and ownership before the measure is finalized for any program. If CMS chooses to move forward with the measure as currently specified and tested, we request that hospitals be given at least 18 months to prepare to report the measure followed by two years of voluntary reporting prior to any mandatory use.

Proposed Removals from the Measure Set (Part IX.C.4)

CMS proposes to remove three measures beginning with the 2028 reporting period/FY 2030 payment determination:

1. Venous Thromboembolism Prophylaxis (VTE-1) eCQM,
2. Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM, and
3. Discharged on Antithrombotic Therapy (STK-02) eCQM.

FAH agrees that the removal of the VTE-1 and VTE-2 eCQMs under Measure Removal Factor 5 — the availability of a measure more strongly associated with desired patient outcomes — are appropriate; however, we note our concerns with the proposed Hospital Harm–Postoperative VTE eCQM and urge CMS to address those concerns prior to its finalization.

We also support the removal of the STK-02 eCQM under Measure Removal Factor 1 — topped-out performance. Hospital performance on this measure has reached a level of uniformity that no longer allows for meaningful differentiation or quality improvement. Continued inclusion of a topped-out measure imposes reporting burden on hospitals without generating information that is actionable or useful for patients, purchasers, or policymakers.

Proposed Modifications to Current Measures in the Hospital IQR Program Measure Set (Part IX.C.5)

CMS proposes modifications to three excess days in acute care (EDAC) quality measures beginning with the July 1, 2024, through June 30, 2026, performance period, associated with the FY 2028 payment determination:

1. Expanding to include MA patients
2. Reducing the performance period from three years to two years
3. Updating the risk adjustment model to use individual ICD-10 codes instead of HCCs

We reiterate our concerns on the timing of these changes and need for immediate transparency of the model specifications. Hospitals must have these details to understand the potential impact to their performance scores and enable them to continue to drive quality improvement to their patients.

Request for Information (RFI): Birthing-Friendly Hospital Designation Modification to Expand Designation Criteria

CMS seeks input on potential modifications to the Birthing-Friendly Hospital Designation, specifically on the inclusion of the Cesarian Birth eCQM and Severe Obstetric Complications eCQM in the criteria for awarding the Birthing-Friendly Hospital Designation, and a modified scoring methodology for the expanded designation.

FAH recommends that CMS postpone any consideration to include these two eCQMs in the designation until hospitals gain additional experience with these measures and have access to national performance scores and benchmarks. Because these measures only moved to mandatory reporting this year, hospitals have not had sufficient time to evaluate their performance and at least one more year of implementation and benchmarking would be helpful before any consideration to incorporate them into this designation is proposed. Once performance data are readily available, evaluations on the weighting and clustering should be completed.

Form, Manner, and Timing of Quality Data Submission (Part IX.C.8)

CMS proposes to change the reporting and submission requirements for eCQMs and structural measures. Specifically, the Malnutrition Care Score eCQM would shift to mandatory reporting beginning with the 2028 reporting period/FY 2030 payment determination. Beginning with the same reporting period, any Hospital Harm eCQM that has not been finalized for mandatory reporting would become mandatory in its third year. Lastly, CMS proposes to update the reporting requirements for the Maternal Morbidity Structural measure beginning with the 2026 reporting period/ FY 2028 payment determination by asking hospitals to provide the name of the collaborative program if they answer yes that they participate in a perinatal quality improvement collaborative program.

FAH asks that CMS evaluate the need and potential impact of what may appear to be minimal, non-substantive changes to eCQMs. These measure specifications and definitions are used in internal monitoring tools and for many state Medicaid quality reporting programs and any change can require significant work and burden for hospitals with broader implications beyond just CMS quality programs. For example, the OPI-506 Safe Use of Opioids – Concurrent Prescribing eCQM is also included in Medicaid measure reporting for Texas and recent changes to the definition substantially altered the denominator exclusion criteria, which impacted both 2024 and 2025 reporting and required a full rerun of patient data. In 2024, denominator exclusions included patients with a cancer diagnosis. In 2025, the exclusion criteria were revised to include patients with a cancer pain diagnosis, patients receiving medication for opioid use disorder, patients with sickle cell disease, and patients who leave against medical advice. These changes significantly affect the measure population and may substantially alter reported performance independent of any change in prescribing practices or clinical care.

Another example is the proposed change to the Maternal Morbidity Structural measure, which is also included in New Mexico's Medicaid program. Frequent changes to the measure require more than attestation changes and will disrupt existing state improvement metrics. CMS must be thoughtful about ensuring more stability in the measure specifications given the downstream implications they have to other reporting efforts.

Specifically, regarding the Malnutrition Care Score eCQM, we are concerned with a shift to mandatory reporting given its impact on small, rural, and/or medically underserved hospitals. These facilities often do not have access to a dietitian all seven days of the week and as a result, cannot consistently meet the measure requirements, which sets them up to fail the measure due to resource limitations outside of their control. This unintended consequence of the measure places these hospitals at a disadvantage not only in the Hospital IQR Program but also for any state that chooses to adopt the measure in their reporting requirements.

This type of annual specification change creates a particular challenge for hospitals subject to state reporting requirements that rely on year-over-year eCQM outcomes. When the eligible population changes materially from one reporting year to the next, prior-year performance is no longer directly comparable to current-year performance. As a result, hospitals may appear to improve, or decline based on changes in the measure logic rather than actual changes in patient outcomes, clinical practice, or quality improvement efforts.

FAH asks that CMS be more judicious in its updates to the measure specifications given the burden placed on hospitals to be responsive to these changes, particularly as the list of mandatory measures continues to grow. In addition, it is critical that CMS be more aware of the effect that any update has to other implementers such as state Medicaid programs and allow hospitals more time to implement these eCQMs, develop monitoring tools to support their use, and provide sufficient lead times given their impact on other users.

XV. LTCH Quality Reporting Program (QRP) (Part IX.E)

Proposed Removal of Two COVID-19 Measures (Part IX.E.2)

CMS proposes to remove the Healthcare Professionals (HCP) COVID-19 Vaccine and COVID-19 Vaccine: Percent of Patients/Residents Who Are Up To Date measures, beginning with FY 2028 LTCH QRP, under measure removal factor

3, which is due to the lack of alignment with the current clinical guidelines or practice. FAH agrees with removing these measures to align with previous changes made to other quality reporting program.

Request for Information: LTCH QRP Measure Concepts Under Consideration for Future Years (Part IX.E.5)

CMS seeks input on the importance, relevance, appropriateness, and applicability of the quality measure concept of advanced care planning for future years in the LTCH QRP.

FAH supports patient-centered care and recognizes that advance care planning is an important component of high-quality care across the continuum. However, any measure considered for inclusion in this program must be sufficiently tested to ensure that hospitals can capture the required data in a reliable and valid manner, particularly if it is put forward as an eCQM. Based on hospitals' experiences with the data elements required for the Hybrid Hospital-Wide All-Cause Readmission measure, we know that limited testing in only one or two EHRs does not provide sufficient information to ensure that the required data can be captured through existing workflows and it will take time for hospitals to complete the additional mapping and education required to successfully capture the data. The numerator requirements will need to comply with any individual state requirements, and the measure should also ensure that an individual's religious and/or cultural beliefs can be honored; specifically, the measure should include an exception or guidance allowing the documentation of a discussion to account for those individuals for whom the conversation would be forbidden. We believe that CMS should only propose measures once widespread testing across more EHRs and hospitals of varying size, location, and ownership is completed.

Form, Manner, and Timing of Data Submission under the LTCH QRP (Part IX.E.6)

CMS proposes beginning with the FY 2029 LTCH QRP that LTCHs be required to complete their data submissions and make corrections, as necessary, to their assessment data and CDC NHSN data no later than the 15th day of the second month after the end of the calendar quarter, except if such 15th day falls on a Friday, weekend, or Federal holiday the deadline would be delayed until the next business day.

FAH appreciates the desire for data that are timelier and up to date on the quality of care delivered by LTCHs. However, while most facilities currently submit data within this proposed timeframe, they also must respond to competing demands and often coordinate reporting beyond just the CMS hospital quality programs. **We recommend extending the submission deadline to the last day of the second month after the end of the calendar quarter to ensure that each can successfully report every time.** If CMS opts to finalize this timeframe, then we ask that the deadline is a fixed date rather than a moving target when adjusting for weekends and federal holidays.

XVI. Medicare Promoting Interoperability Program (Part IX.F)

FAH supports ongoing efforts to modernize the program and reduce unnecessary reporting. Hospitals work across complex EHRs environments. Implementation also depends on external readiness, including payers, public health agencies and technology vendors. These dependencies affect whether a measure can be completed reliably across hospital settings.

ONC Health IT Certification Program Proposed Updates Relevant to the Medicare Promoting Interoperability Program (Part IX.F.2)

CMS proposes to remove references to the following certification criteria from the definition of certified EHR technology (CEHRT) at 42 CFR 495.4 for the Medicare PIP: "family health history," "patient health information capture," "automated numerator recording," and "automated measure calculation".
FAH is supportive of the removal of the certification criteria references as they align with the proposed changes in the HTI-5 proposed rule from the Office of the National Coordinator for Health Information Technology (ONC).

Proposal to Remove ONC Direct Review and ONC-ACB Surveillance Attestations (Part IX.F.3)

CMS proposes to remove the mandatory ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation, beginning with the EHR reporting period in 2026.

We agree with removing the two attestations since it will reduce unnecessary work for hospitals while preserving the goals of the Medicare Promoting Interoperability Program. We encourage CMS to confirm in guidance that hospitals

remain encouraged, but not required through Promoting Interoperability attestation, to cooperate with ONC or an ONC-ACB when contacted.

Proposal to Remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures (Part IX.F.4)

CMS proposes to remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures beginning with the EHR reporting period in 2028.

FAH supports CMS's efforts to modernize the Health Information Exchange objective and agrees that the Support Electronic Referral Loops measures may no longer fully reflect the preferred direction of network-based exchange. However, these measures can still serve an important function when external exchange networks are unavailable or during transitional periods, such as when newly acquired facilities are integrating into a different exchange environment. In these circumstances, hospitals may require an alternative mechanism to demonstrate continued engagement in health information exchange activities. Removing these measures without a related exception or transitional accommodation could create compliance risk for hospitals acting in good faith, particularly given the significant weight assigned to the Health Information Exchange objective within the program.

We recommend that CMS delay removal until CY 2029 or create a clear exclusion or hardship pathway before removing the measures. CMS should allow an exception when circumstances outside the hospital's control prevents successful participation despite reasonable efforts. CMS should also clarify the documentation that hospitals must retain to support an exclusion or hardship request.

Proposed Updates to the Electronic Prior Authorization Measure (Part IX.F.5)

CMS proposes to modify the Electronic Prior Authorization measure beginning with the EHR reporting period in CY 2027. The proposal would revise the measure language, require CEHRT certified to prior authorization API criteria, change the applicable event from discharge to encounter, make the measure optional with 10 bonus points in CY 2027 and require the measure beginning in CY 2028.

FAH supports the ongoing focus on electronic prior authorization and supports changing the applicable event from discharge to encounter. Prior authorization work may occur at different points during a hospital encounter, and this change better reflects hospital operations and workflows.

We do not agree with the proposal to change the wording from "using data from CEHRT" to "using CEHRT." The "using data from CEHRT" standard must be retained as this distinction matters. Hospitals frequently use more than one EHR platform, and they may also rely on integrated technology, payer portals, clearinghouses or revenue cycle systems to support prior authorization work. A narrow "using CEHRT" requirement could limit practical implementation options, even when the data come from CEHRT, and the workflow supports the measure's intent.
A certified technology-only approach could create operational risk, increase implementation burden, and force duplicative connections across hospitals, EHR instances, and payers without improving patient care. **CMS should clarify that hospitals may use standards-based intermediary or enterprise-level solutions when those solutions maintain appropriate data integrity, privacy, security, and auditability.**

We also recommend that CMS clarify that hospitals may satisfy the measure when they use data from CEHRT with certified Health IT Modules or interoperable intermediary solutions that are integrated into the hospital's electronic prior authorization workflow. CMS should also clarify that hospitals may use the certified functionality needed for the applicable workflow and should not require every prior authorization capability in every setting or require all functionality to come from a single vendor.

We strongly support the CY 2027 optional bonus approach. **CMS should continue optional or no-penalty reporting through CY 2028 and delay mandatory compliance until no earlier than CY 2029.** Hospitals need time to procure, configure, test, train and operationalize these workflows. Hospital compliance should not depend on payer API readiness or uneven availability of standards-based functionality across markets.

Before requiring the measure, CMS should provide clear guidance on the hospitals' workflows that may satisfy the attestation requirement. This guidance should address admission-related authorization activity, continued stay and utilization review processes, authorization activity that occurs after care has begun, and workflows where the hospital

supports or completes part of a prior authorization process initiated by another provider. CMS should also clarify whether hospital outpatient services associated with a hospital encounter may count, and whether an electronic submission can satisfy the measure when the payer's response or full transaction loop is incomplete or unavailable.

Request for Information on Future Potential Performance-Based Measure of Electronic Prior Authorization (Part IX.F.5.f)

CMS seeks comments on potential future updates that could be made to this measure to incentivize providers to use electronic prior authorization for a more substantial set of the electronic prior authorization requests that they submit over the course of an EHR reporting period. Comment is specifically sought on barriers and challenges small, rural, or otherwise under-resourced hospitals might face reporting a performance-based electronic prior authorization measure.

FAH recommends that CMS should count an electronic inquiry when it produces a meaningful payer response or determination. CMS should defer expanding the measure to drugs or other prior authorization categories until the medical items and services workflow is stable and hospital attestation requirements are clear. It will also be important to avoid performance-based measurement until it has evaluated payer response consistency, transaction completion, workflow burden, and readiness for smaller hospitals.

Proposal to Adopt a Unique Device Identifiers (UDI) for Implantable Medical Devices Measure in the Public Health and Clinical Data Exchange Objective (Part IX.F.6)

CMS proposes to add a UDI measure for implantable medical devices under the Public Health and Clinical Data Exchange objective beginning in CY 2027.

While FAH supports the goal of improving UDI capture, we do not support making this measure required within the Public Health and Clinical Data Exchange objective. Specifically, UDI capture is primarily a patient safety and device traceability function and does not align with the main purpose of the Public Health and Clinical Data Exchange objective where the current measures focus on exchange with public health agencies and registries specific to reporting and population health functions.

In addition, the Public Health and Clinical Data Exchange objective is already complex. Hospitals manage public health agency readiness limits, onboarding delays and exclusion pathways that do not always reflect operational reality. Adding this new measure on UDI would increase burden without improving the objective's central purpose.

The CY 2027 timeline does not provide sufficient notice for the inclusion of a new required measure. Even when discrete UDI capture is available, hospitals must align procedural workflows, staff training, evidence collection and audit readiness. Those steps take time and coordination across hospital operations and supply chain partners.
If CMS proceeds with a UDI measure, CMS should make it optional or bonus only through at least CY 2029 and clarify the following before any required implementation:

1. Whether hospitals may use scanning, manual entry, external lookup or another discrete documentation workflow.
2. The minimum UDI data elements are required.
3. Whether compliance is assessed at the facility, patient, procedure, or device level.
4. What evidence hospitals must retain for audit purposes.
5. Whether workflow constraints or external system limits may support an exclusion or hardship request.

Request for Information on the Future Direction of the Proposed UDIs for Implantable Devices Measure and Additional Options for Utilizing UDI (Part IX.F.6.c)

If the proposed measure is finalized, CMS intends to propose additional modifications to the measure in future rulemaking to further promote the appropriate capture of UDIs within the EHR. It seeks public comments on performance measures and additional UDI options.

FAH believes that a performance-based UDI measure is premature since current workflows are not sufficiently standardized across hospitals and procedural areas to support reliable numerator and denominator construction. There is also no information on which compliance can be determined reliably, nor is there a consistent method for identifying the denominator population. Hospitals rely on clinical documentation and supply chain systems that may not be fully connected. CMS should first issue detailed specifications, test feasibility through voluntary reporting, and allow for a multiyear transition before applying thresholds.

FAH recognizes the importance of accurate UDI data and believes that at this stage, CMS should focus first on clear specifications and practical audit expectations. Real-time validation against the GUDID adds complexity and may disrupt clinical workflows. This level of validation should not be required until basic capture expectations are tested and stable.

FAH supports the broader goal of using UDI data to improve patient safety; however, UDI capture remains primarily a documentation and operational process. Using the data for quality comparison, recall tracking, and cross-system coordination will require additional infrastructure. The clearest value of UDI is in patient safety and device traceability. CMS should use a program pathway that reflects that purpose.

UDI documentation workflows vary across hospitals. Some settings have scanning integrated into clinical workflows. Others rely on manual entry or lookup processes that add work for staff. CMS should not assume that existing tools are sufficient to support a national required measure. Before adding UDI requirements, it will be critical for CMS to work with hospitals, health IT developers, device manufacturers, and supply chain stakeholders to identify practical implementation models.

Clinical Quality Measurement for Eligible Hospitals and CAHs Participating in the Medicare Promoting Interoperability Program (Part IX.F.9)

Beginning with the 2028 reporting period, CMS proposes to adopt and remove the same eCQMs for the Medicare Promoting Interoperability Program as it does for the Hospital IQR Program. Specifically, the two eCQMs would be adopted in the Medicare Promoting Interoperability Program eCQM measure set from which hospitals may self-select to report: (i) Hospital Harm – Postoperative Venous Thromboembolism and (ii) Advance Care Planning. The following three eCQMs are proposed to be removed from the Medicare PIP eCQM measure set: (i) Discharged on Antithrombotic Therapy, (ii) Venous Thromboembolism Prophylaxis eCQM, and (iii) Intensive Care Unit Venous Thromboembolism Prophylaxis.

FAH refers CMS to our specific and detailed comments on the two new eCQMs (Hospital Harm – Postoperative Venous Thromboembolism and Advance Care Planning) outlined above. We reiterate that we are increasingly concerned that these eCQMs are not sufficiently tested as to truly identify whether each can be captured using existing clinical workflows and produce data that are reliable and valid. Additional testing must be completed before inclusion in any program.

We support the removal of the three eCQMs (Discharged on Antithrombotic Therapy, Venous Thromboembolism Prophylaxis eCQM, and Intensive Care Unit Venous Thromboembolism Prophylaxis).

CMS Should Continue Flexibility for Public Health Active Engagement Barriers

Hospitals continue to face public health onboarding delays and state specific requirements. In some cases, a hospital is prepared to proceed, but the public health agency or registry lacks the capacity to onboard the hospital in a timely manner. CMS should update the active engagement exclusions to address delays outside of the hospital's control. Hospitals should not be penalized for external onboarding queues, state system limitations, or registry capacity constraints.

XVII. Proposed Changes to the Transforming Episode Accountability Model (TEAM) (Part X.A)

CMS Lacks the Authority to Mandate Provider Participation in CMMI Models

CMS proposes to continue national, mandatory testing of the Transforming Episode Accountability Model (TEAM). The Federation continues to strongly oppose mandatory provider participation in any Centers for Medicare and Medicaid Innovation (CMMI) testing. FAH has repeatedly expressed significant legal and policy concerns with mandatory CMMI models and has urged HHS to ensure that CMMI acts only within its designated authority to test voluntary alternative payment models. These objections to mandatory demonstrations are particularly acute with respect to the TEAM testing in light of its extraordinarily wide breadth—both in terms of the proportion of subsection (d) hospitals that are mandated to participate and in terms of the proportion of surgical encounters that fall within the five surgical episode categories.

Mandatory provider and supplier participation in CMMI models constitutes an impermissible mandatory change to the Medicare program and runs counter to both the letter and spirit of the law that established the CMMI. CMMI's

demonstration authority is limited to the testing models under section 1115A and the making of recommendations to Congress, but Congress reserved for itself the authority to make permanent or mandatory changes to the Medicare program and the IPPS through legislation.

CMS nonetheless proposes to continue TEAM, a five-year "mandatory model that will be tested under the authority of section 1115A of the Act."[30] Case law, however, confirms that CMS' assertion of authority under section 1115A to mandate a demonstration model is misplaced. In recent years, courts have continued to make clear that constitutional limits inform the scope of agency authority. In particular, grants of authority to agencies must be narrowly construed, and delegations of broad authority should not be presumed to exist. For example, the Supreme Court has been explicit that agencies must have clear Congressional authorization to exercise extraordinary regulatory authority.[31] "Agencies have only those powers given to them by Congress, and 'enabling legislation' is generally not an 'open book to which the agency [may] add pages and change the plot line.'"[32] As such, Congress does not typically use "modest words," "vague terms," "subtle devices," or "oblique or elliptical language" to empower an agency to make a fundamental change to a statutory scheme.[33]

Mandating provider participation in TEAM (and other CMMI models) transforms the methodology through which providers receive Medicare payments from the statutorily mandated, predictable prospective payment system to interim, uncertain payments, and potentially recoupable losses. No such authorization exists or should be presumed to exist here—Congress has not included in the authorizing statute any statements indicating that it intended to and actually did delegate its lawmaking role to CMS to require providers to accept this different, unpredictable payment scheme in lieu of full IPPS payments for these services. Rather, section 1115A(g) indicates Congress reserved the authority to adopt such fundamental alterations for itself.

Notably, were Congress to have clearly articulated such a broad delegation of authority to CMS to alter the Medicare reimbursement scheme (again, it has not), it would need to provide intelligible principles defining the scope of its delegated authority to ensure such a delegation to the agency was constitutionally sound. This is especially true because Congress precluded administrative or judicial review of a substantial number of matters of CMMI demonstration authority under section 1115A(d)(2) to permit the testing of models.

Separately, requiring Medicare providers to participate in TEAM Track 2 or 3, which require participants to be held financially accountable if spending on specified episodes of care exceeds the model's reconciliation target price, means that Medicare providers will be required to furnish medically necessary services to Medicare beneficiaries without payment. CMS has previously taken the position that mandatory demonstrations with two-sided risk do not reduce guaranteed Medicare benefits because model participants are required to provide medically necessary covered services even if such services are not separately payable. However, this approach fails to justly compensate Medicare providers for the use of their services by Medicare beneficiaries in violation of the Fifth Amendment of the United States Constitution and the Medicare Act.

In sum, the mandatory TEAM demonstration is an overreach of agency authority that contradicts the statutory mandate of section 1115A and raises concerns about impermissible delegation of lawmaking authority to the executive branch and unjust compensation for services provided to Medicare beneficiaries. These concerns are particularly acute in light of the extraordinary breadth of testing: Approximately 25 percent of eligible CBSAs were selected and all subsection (d) hospitals within selected CBSAs are required to participate in all five episode-based payment models that are part of the TEAM demonstration. Because section 1115A does not authorize mandatory payment demonstrations, we strongly oppose continuation of TEAM as a mandatory model. Instead, we urge CMS to ensure that all CMMI models are voluntary and designed to test—at an appropriate scale—alternative payment models.

Remove the Total Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome Performance Measure (THA/TKA PRO-PM) from the TEAM model

Referencing the IQR section's concerns, the Federation urges CMS to remove the Hospital-Level THA/TKA PRO-PM from the TEAM model. The design flaws described in IQR, such as no case minimum, an unrealistically high 50% response-rate, inability to exclude non willing participants, and burdensome pre-operative data collection, will likely do more harm than helping to achieve the model's programmatic goals.

Request for Information — Hospital with Physician Ownership Voluntary Participation in TEAM (Part X.A)

As a preliminary matter, to the extent that CMS finalizes the CJR–X model and retains TEAM as a mandatory model, FAH strongly objects to permitting any new subset of hospitals to voluntarily participate in TEAM. In creating TEAM,

CMS permitted a limited voluntary opt-in for hospitals that participated in the Comprehensive Joint Replacement (CJR) model or the Bundled Payments for Care Improvement Advanced (BPCI Advanced) model until the last day of the performance period, but only if the hospital voluntarily requested to opt-in for the *full duration* of the TEAM model performance period during the limited election period that ended on January 31, 2025. Extending voluntary participation to any subset of hospitals in future rulemaking would necessarily limit those new voluntary participants to at most two of the five performance years. **The Federation urges CMS to instead transform the entire model to a voluntary model, keeping the participating hospitals on equal footing. But, if TEAM continues as a mandatory model, adding voluntary participants at this stage would compromise the model methodology while providing no cognizable benefits.** As CMS notes, mixing mandatory and voluntary participation "risks the integrity of the evaluation design and may lead to biased findings undermining the model test."

Moreover, because TEAM participation insulates a hospital from proposed participation in CJR–X, extending voluntary participation in TEAM would not only skew the TEAM model, but it would also effectively create an opt-out of CJR–X, compromising that model as well. **To be clear, the FAH strongly believes that all CMMI models should be voluntary and include opt-out options, but it is inappropriate to make any opt-in or opt-out only available to a subset of hospitals.**

Considering these concerns, the FAH opposes transforming TEAM participation into a hybrid voluntary/mandatory model. In requesting information concerning a potential voluntary participation option for TEAM, CMS focuses only on making voluntary participation available to hospitals with physician ownership. **The Federation forcefully objects to creating a voluntary participation option only for physician-owned hospitals.** Limiting the TEAM opt-in (that also constitutes a CJR–X opt-out) to physician-owned hospitals would create an uneven playing field for hospitals, with only physician-owned hospitals permitted to choose between TEAM and CJR–X participation through a voluntary TEAM opt-in.

To the extent that CMS is considering using a TEAM opt-in to waive any element of the statutory limitation on physician ownership of hospitals, FAH objects in the strongest terms because such a waiver would be unlawful and inappropriate. Such action would be in excess of CMS's statutory authority because CMS is only permitted to waive certain legal requirements under section 1115A(d)(1) "as may be necessary solely for the purposes of carrying out this section with respect to testing models described in subsection (b)." The first performance year of the TEAM model is well underway, confirming that any waiver of the limitations on physician ownership is simply unnecessary for appropriate testing of the TEAM model.

More importantly, it would be inappropriate to allow a physician-owned hospital to operate in violation of the physician self-referral law as part of the TEAM model testing or any CMMI model because models must be capable of being terminated or completed. In the case of a physician-owned hospital that either was not participating in Medicare as a physician owned hospital by December 31, 2010 or that expanded its capacity after March 23, 2010, the hospital cannot comply with the rural provider exception or the whole hospital exception under section 1877(d) and (i) of the Social Security Act, and any physician owners or investors are statutorily prohibited from referring Medicare or Medicaid beneficiaries to the hospital for inpatient or outpatient hospital services or any other designated health services. This effectively precludes Medicare and Medicaid participation by such new or expanded physician-owned hospitals. If such a hospital were to be permitted to participate in the Medicare program through a CMMI model notwithstanding such statutory noncompliance, the termination of the model would either necessitate that the physician owners and investors divest their interests in the hospital or that the hospital terminate its Medicare participation. Because these options would work a fundamental alteration of the hospital or prompt hospital closure, this would pose inherent and significant barriers to the scheduled completion of the model in 2030. In addition, any model being tested must be capable of early termination. Under section 1115A(b)(3)(B), the "Secretary *shall terminate* or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary . . . certifies), after testing has begun, that the model is expected to" improve the quality of care without increasing spending, reduce spending without reducing quality of care, or improve the quality of care and reduce spending. Establishing a model element that cannot be smoothly removed from the model or terminated with the model altogether is not only impractical, it also exceeds the CMS's statutory authority under section 1115A.

Finally, FAH is concerned that using TEAM to permit new or expanded physician owned hospitals that do not comply with section 1877(d) and (i) of the Social Security Act would necessarily produce limited-service hospitals that fail to provide essential emergency services, absorb uncompensated care costs, and otherwise serve the full spectrum of patient needs, harming the delivery system as a whole. Extensive findings from the Medicare Payment Advisory Commission (MedPAC),[34] Government Accountability Office (GAO),[35] and Centers for Medicare and Medicaid Services (CMS)[36] show that current physician-owned hospitals already systematically treat

healthier, better-insured patients while avoiding Medicaid and more clinically complex cases. Rather than fueling a competitive market for care, physician-owned hospitals shift the burden of caring for sicker, uninsured and underinsured patients onto full-service community hospitals, destabilizing local health care systems and undermining the financial viability of hospitals that must maintain emergency services, standby capacity and comprehensive care for all patients. Weakening or waiving these statutory protections would drive up health care spending,[37] exacerbate conflict-of-interest concerns and further erode the stability of the full-service community hospitals that serve as the backbone of America's health care system. These longstanding problems with physician-owned hospitals and their adverse community impacts would be exacerbated within the construct of the TEAM model, which by design is limited to five surgical episodes of care and expressly excludes the larger range of other essential services provided by participating full-service hospitals, including critical emergency services and non-surgical care. As explained above, CMS does not have regulatory authority to permit physician-owned hospitals that fail to comply with section 1877(d) and (i) in TEAM, but even if CMS had such authority, such a waiver would inappropriately skew the market for hospital care, compromise program integrity, facilitate lemon-dropping and cherry-picking by physician-owned hospitals and burden full-service community hospitals, compounding the very problems Congress sought to address when enacting the express limitations on new and expanded physician-owned hospitals in section 1877 of the Act.

Spinal Fusion MS-DRG Updates (Part X.A.2.a.(2))

CMS proposes to add MS-DRGs 523, 524, and 525 to the spinal fusion episode category at § 512.525(d)(4)(i), with conforming updates to the spinal fusion definition at § 512.505. **The Federation supports the proposed conforming changes**, which are consistent with the underlying IPPS MS-DRG classification updates and preserve episode volume in the spinal fusion category. FAH urges CMS to communicate the resulting scaling factor implications to TEAM participants in advance of each performance year.

Episode Attribution and CJR-X Precedence (Part X.A.2.a.(3))

CMS proposes at § 512.537(b)(4) that a procedure performed at a TEAM hospital during the 90-day post-discharge period of an active CJR-X episode would not initiate a TEAM episode, with the associated spending instead included in the CJR-X episode. **The Federation supports this proposal as a sensible application of anchor-hospital accountability for the longer episode and a reasonable approach to avoiding duplicative accountability across the two models.** As set forth in FAH's separate comments on the proposed CJR-X Model, the same principle of avoiding duplicative episode-based accountability supports excluding beneficiaries attributed to a Medicare Accountable Care Organization (ACO) from CJR-X reconciliation when they receive a lower extremity joint replacement at a CJR-X participant hospital.

APC and MS-DRG Update Factors in Prospective Target Prices (Part X.A.2.c.(2))

CMS proposes to add APC and MS-DRG update factor definitions at § 512.505 and to incorporate these factors into the prospective trend factor calculation at § 512.540(b)(7) so that TEAM preliminary target prices reflect HCPCS-APC and MS-DRG mapping and weight changes implemented during the performance year. **The Federation supports this proposal.** Providing TEAM participants with named, prospective update factor multipliers during the performance year materially improves participants' ability to manage to a known target. As set forth in FAH's separate comments on the proposed CJR-X Model, the Federation urges CMS to adopt this same methodological approach in CJR-X rather than the proposed reconciliation-only treatment of APC and MS-DRG changes.

XVIII. Proposed Revision to Provider-Based Location Criteria Regulations Applicable to Off-Campus Facilities or Organizations (§413.65) (Part X.B.)

FAH is concerned with CMS' proposal to eliminate the referral-based pathway to provider-based status for distant inpatient facilities. Current regulations allow distant off-campus HOPDs or off-campus inpatient facilities to obtain provider-based status via one of two location criteria:

- At least 75% of the patients served by the off-campus facility or organization reside in the same zip code areas as at least 75% of the patients served by the main provider (referred to as the "zip code overlap exception") or
- At least 75% of the patients served by the off-campus facility or organization who required the type of care furnished by the main provider received that care from that provider (referred to as the "referral-based exception").

While CMS expresses concern that the current policy may permit certain hospitals to qualify for provider-based status despite geographic separation from the main provider, we believe the referral-based exception continues to serve an important role in supporting clinically integrated systems of care for patients with complex and specialized medical needs.

The existing referral-based criterion appropriately recognizes that patient populations may be linked through established patterns of care rather than geographic proximity alone. For many specialized services, patients may receive routine or follow-up inpatient care at a local hospital while relying on a more distant hospital for specialized treatment, advanced interventions, or management of complex conditions. In these circumstances, the referral relationship reflects meaningful clinical integration and coordination between facilities serving the same patient population.

Accordingly, we urge CMS to retain the referral-based exception for inpatient facilities. Eliminating this pathway could unintentionally limit opportunities for hospitals to establish integrated care arrangements that support access to specialized services, particularly for patients in rural and underserved communities who often rely on coordinated relationships between local providers and distant specialty hospitals.

Endnotes

[1] Social Security Act § 1886(b)(3)(B)(i)(XX), (vii), (ix), (xi)
[2] Information may be obtained from several tables in the downloads section of this website: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data
[3] For SNF PPS, the threshold amount under 42 CFR § 413.337(d)(2)(ii) is 0.5 percentage points. For capital PPS, the threshold amount is 0.25 percentage points as stated in the IPPS proposed rule on page 19817.
[4] Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, "Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019." Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019 (cms.gov).
[5] 85 Fed. Reg. 58797
[6] Under section 7(b)(1)(B)(i), CMS also adopted a –2.9% adjustment in FY 2011 and then retained that adjustment in FY 2012. 76 Fed. Reg. 51,475, 51,497 (Aug. 18, 2011). In recognition of the TMA's prohibition on continuing to apply these adjustments in FY 2013, the adjustments were fully reversed in FY 2013 with a +2.9% adjustment, thereby returning the standardized amount "to the appropriate baseline." 77 Fed. Reg. 53,257, 53,276 (Aug. 31, 2012).
[7] *See* 82 Fed. Reg. 37,990, 38,008–009 (Aug. 14, 2017); 87 Fed. Reg. 48,780, 48,799–48,800 (Aug. 10, 2022)
[8] 77 Fed. Reg. at 53,276
[9] 88 Fed. Reg. 58,640, 58,654 (Aug. 28, 2023)
[10] 90 Fed. Reg. 35,536 (August 4, 2025) (quoting *Fresno Community Hospital & Medical Center* v. *Cochran,* 987 F.3d 158, 163 (D.C. Cir. 2021)).
[11] 90 Fed. Reg. 36,536, 37,246
[12] For FY 2025, CMS finalized a positive national operating CCR adjustment factor despite FAH's and others' concerns that the positive national operating CCR adjustment factor was unreasonable and the product of skewed data reflecting costs incurred during the peak inflationary period in 2022 and early 2023.
[13] *See* WPA Report at pp. 7–10
[14] *See* WPA Report at p. 8-9 (The tables from the WPA report have been reproduced here with minor editing for formatting purposes.)
[15] *See* WPA Report at p. 9-10
[16] 84 Fed. Reg. 42,325.
[17] *Bridgeport Hosp.*, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024).
[18] *Kaweah Delta Health Care District v. Becerra*, 123 F.4th 939 (9th Cir. 2024).
[19] 89 Fed. Reg. 80,405.
[20] 90 Fed. Reg. 18,234.
[21] 90 Fed. Reg.13,032, 13025 tbl. 16-17 (March 19, 2025)
[22] 91 Fed. Reg. 29,526, 29,856 (May 20, 2026)
[23] Although CMS asserts broad rulemaking authority to define new medical residency training programs, a close reading of the statute indicates that CMS's regulatory authority under section 1886(h)(4)(H)(i) is instead limited to "prescribing rules for the application of" cap requirements to newly established residency programs. After *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024), CMS's interpretation of the statutory reference to "programs established on or after January 1, 1995" is not entitled to judicial deference. Nonetheless, in order to provide substantive comments, FAH has assumed for purposes of this letter that CMS has authority to interpret section 1886(h)(4)(H)(i) in 42 C.F.R. § 413.79(*l*).
[24] 74 FR, 43,912
[25] 42 CFR §413.24(d)(1)
[26] PRM 15-1, chapter 23, section 2306
[27] Publication 15-2, PRM Chapter 40, section 4017
[28] 66 Fed. Reg. 3,359

[29] LTCH PPS Reform Principles (March 2026), available at https://fah.org/wp-content/uploads/2026/03/LTCH-PPS-Reform-Principles.pdf.
[30] 90 Fed. Reg. 18,007.
[31] *W. Virginia v. Env't Prot. Agency*, 597 U.S. 697, 732 (2022).
[32] *Id*. at 723.
[33] *Id*. (citing *Whitman v. American Trucking Assns., Inc.*, 531 U.S. 457, 468 (2001); *MCI Telecommunications Corp. v. American Telephone & Telegraph Co.*, 512 U.S. 218, 229 (1994)). *See also Biden v. Nebraska*, 143 S. Ct. 2355, 2372–75 (2023) (Congress did not provide "clear congressional authorization" for the Secretary to act in ways that would in effect fundamentally revise the statutory scheme).
[34] MedPAC. (March 2005) March 2005 Report to the Congress: Physician-Owned Specialty Hospitals. https://www.medpac.gov/document/report-to-the-congress-physician-owned-specialty-hospitals/
[35] GAO. (September 22, 2025). Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation. https://www.gao.gov/products/gao-25-107450
[36] CMS. (2005). Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf
[37] Congressional Budget Office. (March 2010). https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf

Summary of research modeling

FY 2027 Proposed Inpatient Prospective Payment System

Outlier Payments

Date: June 7, 2026

Introduction

Watson Policy Analysis (WPA) was asked to analyze issues and replicate outlier payments from the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) proposed rule. In short, this outlier policy sets forth a set of rules whereby CMS provides payment to inpatient hospitals for a portion of their high cost inpatient cases once particular thresholds are met. CMS describes its methodology and logic starting on page 19807 of the Federal Register.[1] We attempted to replicate the CMS logic and then compared our results and made a variety of adjustments to assess the impact of using different parameters. This report summarizes our findings.

Summary

A summary of findings is as follows:

- WPA was able to come very close to the CMS calculation of the Fixed Loss Threshold (FLT) (within 0.5%).
- WPA replicated other factors that went into the payment calculation.
- WPA was able to replicate the CMS calculation of the necessary adjustment for the target percentage based on the outlier reconciliations reported in the cost reports.
- WPA was able to come close to the estimate of charge inflation.

Background on outlier payments

In the IPPS program, CMS has established the concept of “outliers” to be high cost cases which are paid an additional amount so that providers’ potential losses are limited. When the estimated costs of a case exceed the payment for the case, plus a threshold, CMS will generally pay 80% of the costs that exceed the payment plus the threshold. CMS pays 90% for discharges assigned to one of the “burn” diagnosis related groups (DRGs).

This threshold is known as the “fixed loss threshold” (FLT) and is set prospectively with each rule based on a target that operating outlier payments will be 5.1% of total operating payments, including outliers. This target is determined by simulations of expected payments.

[1] "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2027 Rates; Quality Programs Requirements; and Other Policy Changes”. Published in Federal Register, Vol 91, No. 71, April 14, 2026

Background from CMS on outlier payments can be found at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html

Additional detail is provided by CMS each year in the IPPS rule.

Analysis 1: Replication of the CMS estimated FY 2027 outlier payment from the FY 2027 IPPS proposed rule

WPA estimated payments, including outlier payments from the FY 2025 Proposed Medicare Provider Analysis and Review (MedPAR) Proposed File, following the methodology set forth in various IPPS rules. In modeling payments, WPA used information from the following data sources:

- MedPAR FY 2025 proposed file: contains inpatient hospital claims from FY 2025 that were used by CMS to model proposed FY 2027 payments,
- Table 5 – Weight file: contains the proposed weights for FY 2027,
- Impact file: contains hospital specific characteristics and payment factors,
- DSH Supplemental File: contains uncompensated care per claim payment amounts for providers,
- The FY2027 Proposed IPPS rule, in particular information on cost and charge inflation factors, and
- Inpatient Provider of Services File: contains provider specific information.
- Hospital Cost Reporting Information System (HCRIS) data containing cost reports from providers. This information was used to calculate the adjustment to the outlier target based on the historical outlier reconciliation.

In addition, other factors such as charge inflation, CCR adjustment factors, and standardized payment amounts from the proposed rule were used.

Complete payments were calculated including operating, capital, disproportionate share hospital (DSH), indirect medical education (IME), uncompensated care, etc. for each case, following the CMS methodology. The CMS methodology excludes sole community hospitals, hospitals that have become Critical Access Hospitals (CAHs), and Maryland hospitals.

Please note that the FLT will adjust with the release of the final rule and associated files, in addition to the recalculated weights.

Analysis 2: Comparison of Cost-to-Charge ratios from the FY 2027 proposed rule Impact file and the Inpatient Provider Specific File

As part of the analysis, we compared the CCRs included in the impact file (used in modeling the FLT) with the CCRs from the Provider Specific File (PSF).

For the modeling using the FY 2025 data, used the December 2025 release of the PSF file. Comparing the 3,082 providers listed in the impact file and the December 2024 PSF file, we had a match rate of 92.472% (2,850 providers).

Using this data, the average difference in operating CCRs between the impact file and the PSF file (weighted by discharges) was -0.065% when all providers were used, and -1.283% when just providers with differences were used.

For the modeling using the FY 2025 data, used the March 2026 release of the PSF file. Comparing the 3,088 providers listed in the impact file and the March 2026 PSF file, we had a match rate of 74.432% (2,294 providers).

Using this data, the average difference in operating CCRs between the impact file and the PSF file (weighted by discharges) was 0.052% when all providers were used, and 0.204% when just providers with differences were used.

The table of matching statistics reported nearly nine years ago in a report from The Moran Company – “Modeling Fiscal Year 2015 Inpatient Prospective Payment System Outlier Payments” dated June 23, 2014, and then updated with WPA calculated data is as follows:

IPPS Rule for FY	Matching Rate Between Impact file and Most recent PSF CCRs	Average Percent Difference Between the Impact File and Most Recent PSF Operating CCR of the Same Hospital (weighted By Discharges)
Final 2010*	93.2%	0.4%
Final 2011*	96.4%	0.1%
Final 2012 - Dec 2010 Update	96.9%	0.2%
Final 2012 - March 2011 Update	65.3%	1.6%
Final 2013	92.1%	0.0%
Final 2014	97.2%	-0.1%
Proposed 2015 - Dec 2015 Update	98.8%	-2.7%
Proposed 2015 - March 2015 Update	64.8%	1.0%
Proposed 2016 - Dec 2015 Update	89.6%	-0.02%
Proposed 2016 - March 2015 Update	61.6%	0.19%
Proposed 2017 - Dec 2016 Update	94.16%	-0.014%
Proposed 2017 - March 2017 Update	65.70%	0.236%
Proposed 2018 – December 2017 update	94.33%	-0.017%
Proposed 2018 – March 2018 update	67.33%	-0.342%
Proposed 2019 – December 2018 update	97.33%	-0.002%
Proposed 2019 – March 2018 update	67.69%	0.240%
Proposed 2020 – December 2018 update	97.49%	-0.027%
Proposed 2020 – March 2019 update	70.12%	0.209%
Proposed 2021 – December 2020 update	97.49%	-0.027%
Proposed 2021 – March 2020 update	70.12%	0.209%
Proposed 2022 – December 2019 update	96.35%	-0.648%
Proposed 2022 – March 2020 update	68.49%	-0.208%

Proposed 2023 – December 2021 update	75.23%	0.119%
Proposed 2023 – March 2022 update	78.59%	0.001%
Proposed 2024 – December 2022 update	96.34%	0.001%
Proposed 2024 – March 2023 update	73.40%	-0.002%
Proposed 2025 – December 2023 update	93.86%	-0.035%
Proposed 2025 – March 2024 update	72.30%	-0.722%
Proposed 2026 – December 2025 update	96.49%	-0.087%
Proposed 2026 – March 2025 update	71.84%	0.246%

* Vaida Health Data Consulting, Modeling FY 2013 IPPS Outlier Payment. June 11, 2012

Note that WPA developed new programs to analyze the data, so there may be differences with the previous analyses by The Moran Company and Vaida Health Consulting. However, the matching percentage calculated by WPA is within a similar matching percentage as that calculated by the Moran Company. In addition, the average difference in operating CCR is much smaller.

Analysis 3: Fixed Loss Threshold over time

From examining the fixed loss threshold in proposed rules and final rules, there is a pattern of the fixed loss threshold declining. The following table shows the fixed loss thresholds for recent years.

FY	Final	Proposed	Variance	% of Variance
2009	$ 20,045	$ 21,025	$ (980)	-4.66%
2010	$ 23,140	$ 24,240	$ (1,100)	-4.54%
2011	$ 23,075	$ 24,165	$ (1,090)	-4.51%
2012	$ 22,385	$ 23,375	$ (990)	-4.24%
2013	$ 21,821	$ 23,630	$ (1,809)	-7.66%
2014	$ 21,748	$ 24,140	$ (2,392)	-9.90%
2015	$ 24,626	$ 25,799	$ (1,173)	-4.55%
2016	$ 22,544	$ 24,485	$ (1,941)	-7.93%
2017	$ 23,573	$ 23,681	$ (108)	-0.46%
2018	$ 26,537	$ 26,713	$ (176)	-0.66%
2019	$ 25,769	$ 27,545	$ (1,776)	-6.45%
2020	$ 26,552	$ 26,994	$ (521)	-1.93%
2021	$ 29,064	$ 30,006	$ (942)	-3.31%
2022	$ 30,988	$ 30,967	$ 21	0.07%
2023	$ 38,859	$ 43,214	$ (4,355)	-11.21%
2024	$ 42,750	$ 40,732	$ 2,018	4.95%
2025	$ 46,217	$ 49,237	$ (3,020)	-6.13%
2026	$ 40,397	$ 44,305	$ (3,908)	-8.82%
2027		$ 51,704		

Note: FY 2023 is based on the proposed blended weight for weighting. Final rule FLT is also blended. Methodology for FY2023 final rule FLT is different than the proposed rule due to the blending, so change from proposed to final should be viewed with caution and not a standard change.

Note: FY 2024 reverted back to not using blended weight or FLT.

Note: FY 2025 Final is as published in the FY 2025 Interim Final Rule with Comment (IFC) version.

Analysis 4: Outlier Reconciliation

In the FY2020 IPPS rule, CMS finalized a new methodology to adjust the outlier target percentage to account for outlier reconciliation. For the FY 2027 rule, CMS is continuing to implement the updated methodology finalized in the FY2025 Final IPPS rule. This updated methodology accounts for the new criteria put forth in Change Request (CR) 13566 issued in 2024. The CR instructs MACs to expand the criteria for cost reports that can be considered for outlier reconciliation. Instead of needing a discrepancy of +/- 10 “percentage points” between the actual operating CCR and the operating CCR used for outlier payment during the same time period, the new criterion is +/- 20 “percent”. This change results in more hospitals being evaluated for outlier reconciliation.

WPA was successful in replicating the CMS calculations given the logic described. WPA matched their rounded calculation of 0.0% when using the FY 2021 cost report data released

with the December 2025 update of HCRIS and the CMS issued Public Use File for the imputed amounts calculated from data supplied by the MACs.

CMS however views this as “inconsistent with historical data”, and is proposing to still use the calculation from the FY2025 Final IPPS rule.

The March 2026 release of HCRIS, the March 2026 update to the Provider Specific File, and presumably updated data from the MACs will be used in the final rule. As WPA does not have access to the data feed from the MACs, we cannot estimate the final rule results at this time.

Analysis 5: Explorations on high charge cases

As evidenced in Analysis 3, the Fixed Loss Threshold has been adjusting over time, generally increasing. In response to this, WPA conducted various examinations and probing of the data and other issues that may relate to the Fixed Loss Threshold.

No single, definitive, cause for the increase was identified. However, one intriguing finding of this research was:

a) The impact of “extreme” cases on the Fixed Loss Threshold; and
b) The increase in the rate of “extreme” cases.

In the IPPS rate-setting process, statistical outliers – extreme cases – generally are removed from the calculations during the normal methodology. However, these cases are left in during the calculation of the Fixed Loss Threshold.

To examine this issue, WPA tested trimming out cases with covered charges greater than particular thresholds. This removed the case if the ***covered charges*** were greater than a threshold.

The following table shows the results at different trim points when using the proposed blended weights data.

Scenario	Cases remaining	Removed cases	FLT	Percentage of cases removed
Base	6,754,195	0	$51,830	0.00
Trim at: 5,000,000	6,753,862	333	$49,851	0.00
Trim at: 4,750,000	6,753,817	378	$49,701	0.01
Trim at: 4,500,000	6,753,760	435	$49,471	0.01
Trim at: 4,250,000	6,753,663	532	$49,176	0.01
Trim at: 4,000,000	6,753,514	681	$48,768	0.01
Trim at: 3,750,000	6,753,325	870	$48,313	0.01
Trim at: 3,500,000	6,753,106	1,089	$47,826	0.02
Trim at: 3,250,000	6,752,802	1,393	$47,102	0.02
Trim at: 3,000,000	6,752,477	1,718	$46,400	0.03
Trim at: 2,750,000	6,752,036	2,159	$45,680	0.03
Trim at: 2,500,000	6,751,424	2,771	$44,813	0.04
Trim at: 2,250,000	6,750,500	3,695	$43,801	0.05
Trim at: 2,000,000	6,749,335	4,860	$42,755	0.07
Trim at: 1,750,000	6,747,683	6,512	$41,495	0.10
Trim at: 1,500,000	6,745,018	9,177	$39,903	0.14
Trim at: 1,250,000	6,740,130	14,065	$37,804	0.21
Trim at: 1,000,000	6,730,456	23,739	$34,942	0.35
Trim at: 750,000	6,706,647	47,548	$30,810	0.70
Trim at: 500,000	6,635,227	118,968	$24,514	1.76
Trim at: 250,000	6,275,778	478,417	$14,217	7.08

Removing a relatively small number of cases can have the impact of shifting the Fixed Loss Threshold potentially thousands of dollars.

As was noted in previous years, the number and proportion of very high charge cases (defined here as having *covered charges* greater than $1.5 million) have been increasing over time. In the FY2024 data, this trend continued. (Note: The FY2023 data has been updated to final rule data.)

Year	Number of cases over $1.5 million	Percentage of total cases	Number of unique providers
2011	926	0.0088%	272
2012	994	0.0098%	272
2013	1,092	0.0111%	283
2014	1,329	0.0141%	306
2015	1,539	0.0161%	320
2016	1,733	0.0185%	334
2017	2,291	0.0250%	403
2018	2,650	0.0286%	398
2019	3,128	0.0348%	441
2020	3,666	0.0474%	474
2021	4,719	0.0650%	530
2022	5,482	0.0803%	594
2023	6,620	0.0980%	607
2024	7,460	0.1108%	614
2025	9,306	0.1375%	660